

MEDICAL PRAGMATISM:
A STUDY OF SICKNESS AND HEALING
AMONG THE FÜR

Ann C Rose

TWO VOLUMES

Ph.D. in Social Anthropology
University of Edinburgh
1983



DECLARATION

I declare that the facts and ideas contained
in this thesis are the results of my own
research, unless otherwise stated.

A handwritten signature in black ink, appearing to read "Ann C. Rose". The signature is fluid and cursive, with a long horizontal stroke extending from the end of the name.

Ann C Rose

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USE OF TERMS

A number of the terms used in this thesis need special attention and explanation.

'Modern' and 'country' are terms used to denote and distinguish between medicine as it is taught in university medical schools and teaching hospitals internationally, and that which is taught and practised indigenously by individuals living in small scale, technologically simple societies, passed on from father to son, mother to daughter or by apprenticeship to an expert. The indigenous medical beliefs and practices among the Fūr are known as el-tibb el-balady,¹ literally, the medicine of the country, as distinct from el-tibb el-hadīth,² the new or modern medicine which was introduced into Darfur during the early decades of this century. The term 'modern' is arguably no more value-loaded than alternatives such as 'western' and 'scientific', or 'cosmopolitan', favoured by Dunn (1976) and Leslie (1976). Modern and country have the added advantage of being idiomatic. Modern medicine is regarded by the Fūr themselves as being something new, experimental and contemporary while country medicine is traditional, time-honoured and comforting.

'Practitioner of medicine' is the term most often used in this study when referring to those who practise any sort of therapy designed to preserve or restore health. The terms 'practitioner of country

-
1. el-tibb el-balady (Ar.) is used throughout Northern Sudan and is used by the Fūr rather than any other term. To an inexpert ear it seems that the Fūr soften the arabic 'ṭ' to 't';
 2. el-tibb el-hadīth (Ar.) is altered likewise and the aspirated 'h' becomes 'h'.

medicine' and 'practitioner of modern medicine' indicate the fields of medicine in which these individuals operate. There is a small number of practitioners of medicine who operate in both fields, having their base in country medicine while utilizing some of the techniques and therapies of modern medicine. This type of therapist is termed a 'general practitioner'. Occasionally, the term 'healer' is used ... as an alternative collective term when discussing all varieties of practitioner generally, as is 'therapist'.

'Sickness' has been chosen as the term to denote the condition of 'loss of health' rather than 'illness' or 'disease' which carry overtones of modern, western medical terminology; it can be used both emically and etically and is a suitable translation of marad (Ar. marad) as used by the Fūr. Occasionally, however, other terms are used as alternatives to give some relief to the reader from the repetition of this noun and its verbal form; individuals may be asked about being 'ill', and 'illness' and 'disease' do have their place. 'Ailment' is another occasionally utilized term.

The terms 'mystical' and 'natural' were important antitheses in the proposal for this research, being used in the classification of causes of sickness. However, a classification along the lines of 'mystical' and 'natural' was seen to be too simplistic when the research material was analysed and so has been abandoned, but the terms are retained in the thesis; 'mystical' describes those phenomena which are supra-sensible and whose presence cannot be verified, as opposed to phenomena which are 'natural', i.e. observable or able to be deduced by observation, and which are not supra-sensible. This is in line with the definition given by Evans-Pritchard (Evans-Pritchard, 1937:12).

TRANSLITERATION AND ABBREVIATIONS

In general I have attempted to use the minimum of diacritical marks in the translation of Fūr and Arabic words. To the inexpert ear, it seems that the Fūr often soften (or do not emphasize) some of the more typically Arabic sounds -- such as those which are transliterated as ṭ ḍ ṣ ḥ. Diacritical marks have been used for long vowels where they help in pronunciation for the non-Arabic speaker. The name of the people, the Fūr, is pronounced similarly to 'four' rather than to 'fur' in English. Most Arabic plurals are rendered by the addition of the English 's'.

The following abbreviations have been used:

Ar. - Arabic

F. - Fūr

L. - Latin

ACKNOWLEDGEMENTS

First of all I would like to express my thanks and appreciation to Dr Mary Noble for her supervision and moral support during my studies at the University of Edinburgh and in Darfur.

I am deeply indebted to the Fūr people for their kindness and helpfulness throughout my stay among them, and for sharing their beliefs and medical practices with me. In order to protect practitioners of country medicine from immediate recognition - they are, strictly speaking, infringing modern medical proprieties - I have used pseudonyms for most informants as well as for the two communities where the field research was centred.

There are many other people who offered assistance, hospitality and sincere friendship at different stages of the research, in Darfur, Khartoum and Edinburgh. I would like to express my gratitude to them all.

My colleagues, Musa Abdel-Jalil and Houshang Philsooph, have always been willing to share time for discussion, for which I am most appreciative. Musa and his wife, Nagwa, were my first Darfurian informants. They welcomed me into their family here in Edinburgh and then opened doors for me in Sudan by numerous introductions to friends and relatives. I cannot thank them enough.

I would like to thank the staff of the Inter-Library Loan Department, University of Edinburgh for their patience and co-operation in obtaining many, and sometimes obscure, references.

My thanks are also due to Mrs Grace Young for the impeccable typing of this thesis.

The fieldwork upon which this thesis is based was undertaken with the aid of a studentship from the Social Science Research Council, to whom I am most grateful.

Finally, I would like to thank my parents for their constant support throughout the whole period of this research.

ABSTRACT

The Fūr live at the heart of Africa, far from the sea and remote from the Sudanese capital, Khartoum. They inhabit small mountain villages on their ancient stronghold, Jebel Marra, and others along the banks of seasonal rivers which flow from the massif; they also live in neighbourhoods of Zalingie town. Their lives revolve around the land and its produce and the terraced hillsides (up to 2700m) are evidence of their determination to farm their staple food, millet. For some years now, the Fūr have felt the effects of the Sahelian drought and their once green and fertile land is suffering desertification, especially in the more northerly areas. Despite their remoteness, however, the Fūr are very aware of the process of modernization in Sudan and wish to participate in it.

This study aims to give an ethnographic account of the Fūr people and their system of medicine, focussing specifically on sickness and its cause, the conduct of sickness and the practice of medicine by the numerous practitioners of country and modern medicine to be found in Darfur - the land of the Fūr, now the most westerly region of Sudan.

The Fūr are Muslims and their most renowned and respected practitioners of medicine are the fegis - students and teachers of the Qur'an - who use the holy word, written and spoken, dissolved in water and in the form of smoke, as prophylaxis and therapy for almost

any ailment. However, despite the reputation of Fūr feqis throughout Sudan, the Fūr themselves are remarkably pragmatic in their explanation of sickness and generally show a preference to take advantage of modern medical drug therapy, if this is readily available, when they personally experience sickness.

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Part I of the thesis is generally ethnographic and comprises chapters designed to acquaint the reader with the Fūr people and their homeland - Darfur: it will also give a brief historical overview in which Fūr contact with the outside world can be recorded and the influence of Islām and Islāmic culture assessed

Chapter 1

INTRODUCTION

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1.1 THEORETICAL ASPECTS

Ideas for this research developed during and following time spent in Nigeria and Dubai, United Arab Emirates, while working as a physio-therapist. Observations made in Dubai supplemented library research for a dissertation¹ concerning the preventive and therapeutic aspects of concepts of sickness in Islamic communities. This dissertation referred to features which seemed to be fairly general throughout the area termed the 'Arab East' (the Muslim-Arab countries of the Middle East, including Egypt, Sudan and the Saudi Arabian peninsula), such as the evil powers given character in the evil eye, shaytāns, sorcery and the jinns,² and the practices engaged in to prevent or remedy the effects of these powers. Much of the information came from old 'traveller's tales', as there is little in the more recent anthropological literature concerning healing practices, concepts of sickness cause and the organization of medicine in this part of the world. This prompted the present study, which attempts to give an account of sickness and healing in a Muslim society and to examine the effects of modern medicine³ on the beliefs and practices associated with sickness and healing among the Fūr of Western Sudan.

This thesis constitutes a record of intensive fieldwork research among two Fūr communities with regard to their ethnography and beliefs and

-
1. Concepts of sickness in some Islamic communities: preventive and therapeutic aspects. (Unpublished post-graduate diploma dissertation, London School of Economics, 1977.)
 2. Shaytāns (Ar.) and jinns (Ar.) devils and spirits.
 3. See 'use of terms' p.viii.

practices regarding sickness, and a less intensive study of healers and their healing practices throughout the area inhabited by the Fur, in the Western District of Darfur Region, the westernmost part of Sudan.

In most parts of Sudan, el-ṭibb el-balady, (Ar.) country medicine, and el-ṭibb el-ḥadith (Ar.), modern medicine, are found. Darfur is an area where, according to Sudanese in Khartoum, 'country medicine is flourishing' and where 'the healers are very powerful'. These healers, practitioners of country medicine, are encountered in every community in Darfur as general practitioners - such as feqis,¹ who are religious teachers as well as practitioners of country medicine, and certain housewives, who besides being mothers and farmers are recognized as having some specialized knowledge about healing and who are consulted by their kinfolk and neighbours, although they would not regard themselves as healers, probably. Not every specialist is to be found in every community but, in general, would be contactable without too much difficulty.

In most Fūr villages modern medicine is also known to the majority of inhabitants. A network of primary health care units and practitioners of modern medicine throughout Darfur means that most people are today within a 15 km (9-10 mile) radius of modern medical care. The Fūr make a definite distinction between country and modern medicine, country and modern therapies, and between practitioners of country medicine and practitioners of modern medicine in discussion, but their decisions regarding choice of healer or therapy rest on other criteria, such as time, distance, previous contact and, perhaps, cost. Modern medicine, in practice, is simply regarded as another alternative in the therapeutic

1. Feqi (coll. Ar.) from faqih - (legist, jurisprudent, theologian).

repertoire available. Modern drug therapy has changed the nature of much disease and the Fūr are keen to benefit from its utilization wherever possible. When speaking of 'medicine' the Fūr use the word as a comprehensive term incorporating all forms of 'the art of preserving and restoring health'.¹

In the next section I will describe the aims of the study and this will be followed by a review of the literature. While researching for the dissertation mentioned above, it became clear that there was a gap in the anthropological literature concerning studies of medicine among Muslim peoples. A review of the literature in the fields of medicine and of ethnographic accounts of Muslim communities will highlight the gap suggested above.

1.2 AIMS OF THE STUDY

Considering the background information gained from library research and discussion with Sudanese colleagues, the research proposal for this thesis was formulated along fairly conventional lines, with the following aims:

1. To portray the beliefs and practices relating to sickness and healing in a Muslim society by:
 - (a) giving a general ethnographic account of the Fūr people;
 - (b) focussing on the field of sickness and investigating the conceptualization and classification of sickness;
 - (c) examining the conduct of sickness and portraying the various practitioners of medicine and their therapies; and
 - (d) considering the extent to which sickness classification affects the choice of healer and therapy.

1. Oxford English Dictionary definition of 'medicine'.

2. To examine the effect of availability of modern medicine on the practices of the Fūr and to make a general study of social change in the field of medicine in a technologically simple society. An attempt is made here to illustrate social change, since the advent of modern medicine in the Condominium period, with data obtained in a remote rural mountain community and in a neighbourhood of a small market town in the lowlands.

With these general aims in mind, the following hypotheses were formulated:

I. Among the Fūr, concepts of sickness have their basis in religion and are closely involved with personal social relations, the restoration of which (following impairment or dysfunction) is in the province of the practitioner of medicine.

II. Changes will be seen in the concepts of sickness cause and pursuit of therapy where there has been an increase in opportunities for contact with other peoples; this change will involve innovations and adaptations to accommodate modern medicine in both the role of the healer, and the sick individual and his/her family.

3. To show the way in which a research programme of this type could be of value in planning health services in low-income countries. The study of the medical system as a complete system of ideas, beliefs and practices takes account of country and modern medicine as aspects of the one system. The point of view of the people themselves, as they explain their reality is as important as the view of the observer, if a thorough acquaintance with the society is to be gained. Information of this type, it is hoped, would facilitate the planning of health services in which the community would become involved and which would aim at providing the initial impetus and guidance for individuals to endeavour to improve the quality of their

own life and health.

This thesis is presented then both as a contribution to our knowledge of sickness and healing in a Muslim society and as an aid to those who are actively involved in introducing relevant medical facilities in developing countries.

I should like to set out in some detail in the next three or four pages, the assumptions which underlay the research proposal. With regard to the hypotheses, it was supposed that the Fūr, as rural agriculturalists living mainly in remote villages and having little contact with the modern, technological outside world, would be concerned with their religion and their subsistence. The communities which inhabit neighbourhoods of the small market town of Zalingie would show some degree of urbanization and thus, a comparison could be made of rural and urban life which would indicate where social change had taken place.

As far as the rural Fūr are concerned, it was supposed that, as conversion seems to have occurred unevenly and over a long period,¹ some non-Islamic, Fūr traditions might still be present. If so, such non-Islamic traditions might well be related to healing practice and, more importantly, to the basic concepts of sickness causation. Thus, as far as the first hypothesis is concerned, it was expected that sickness would be interpreted as being due to some form of 'misdeed' rather than 'mischance' in the majority of instances. The individual and/or close kin would then determine the specific cause of sickness or category

1. al-Tunisi's account (he was in Darfur 1803-11) notes the Fūr nature of court and state rituals. After this time the sultans began to build mosques. For more detail see Chapter 2 and also O'Fahey, 1979 and 1980.

of cause and would seek treatment, entering the appropriate field of ritual or empirical healing practice, under the care of the relevant healer.

The system of medicine among the Fūr was then conceptualized as a dynamic plan of alternatives in which the sick individual either visits a diviner or makes an initial choice of healer (consequent upon determination of the cause of sickness) and subsequently gains a cure under this healer's sphere of influence. If a cure does not follow therapy, the sufferer is then directed towards other spheres by the healer or a diviner until rehabilitation to health results or the disease or injury proves fatal. This system was termed 'spheres of sickness' (Figure 1) rather than the possible alternative, 'spheres of healing', due to the fact that healers were believed to be chosen with reference to the cause of sickness. The spheres of sickness, shown in the figure below, indicate the possible options open to the sick individual and the possible routes through the spheres which he or she might take during an episode of sickness.

If the route through the spheres of sickness chosen by the sufferer was beneficial, and healing and complete rehabilitation resulted, then the individual would pass out of the sphere of that healer to the sphere of health. If, on the other hand, healing did not take place, then the sufferer would perhaps try another healer and move into his sphere, or perhaps try to treat himself. If the sickness proved fatal, then the individual would pass on out of the system at death.

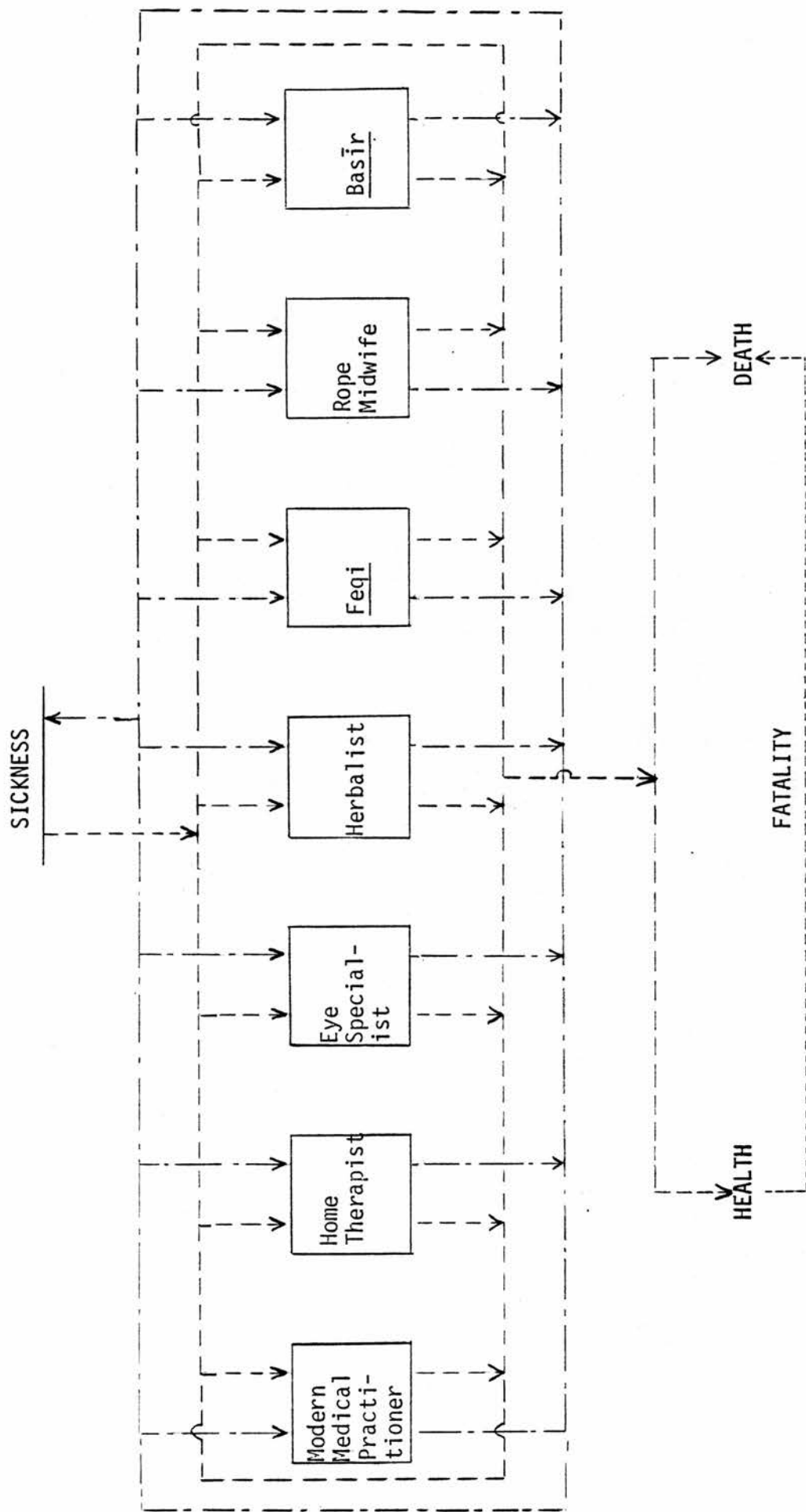


FIGURE 1: SPHERES OF SICKNESS

Some healers in urban areas, it was believed, might have some interprofessional relationship with modern medical practitioners, as the late Tigani el-Mahi, the Sudanese psychiatrist, had established in Khartoum. Such a relationship, though considered indefensible by Western standards has proved extremely worthwhile, both in Nigeria and Sudan according to Lambo, (Lambo, 1964:450).

Initial entry into a sphere of sickness could be followed by entry into any other sphere, if that healer agreed to treat the sick individual, though of course some spheres are limited to certain areas of sickness or incapacity, such as that of the midwife, the eye practitioner and, to a certain extent, the bone-setter who may be purely a manipulator of bones and joints or may utilize a number of other techniques for diverse afflictions. The fegi, the herbalist, the home therapist and the practitioner of modern medicine are more general practitioners of medicine.

This hypothesized system of spheres of sickness rests on the supposed concepts of sickness cause being based on certain beliefs concerning mystical phenomena, such as spirits, witchcraft and sorcery, the latter two involving inter-personal social relations. All three phenomena are recognized in Islām due to their mention in the Qur'an, although witchcraft and sorcery are not approved; it is in this area particularly that Islam has adopted and assimilated (or 'embraced' to use Gibb's term (Gibb, 1975:15)) the traditions of the societies where conversion has occurred. Thus, it seemed possible that here was a society of agriculturalists living in fairly close proximity to each other in small villages, who might well regard sickness as being due to the misdeeds of others against them, if such traditional beliefs as

witchcraft and sorcery were retained and assimilated in Islam. Such misdeeds might then be seen to warrant mystical retribution. In order to maintain or restore social relations in a relatively small and closely-knit society, some method of harmonizing and repairing would be necessary and in the field of sickness and healing the traditional healer, the practitioner of country medicine, might be seen to perform a vital mediating role. The therapies and prophylaxes prescribed by this individual would take account of the relative social relations between the sick person and others in his cosmos. The mediation/medication provided by the healer would gain moral as well as medical cure, (Carstairs, 1955:133).

The model of spheres of sickness (Fig. 1) was devised in order to indicate the alternatives in healing practice. Such a model could also be used to illustrate changes in choice of healing practice over time. Initially, change could be shown by illustrating the model with evidence from a remote rural community and a community living in a small market town known to have been slowly expanding during the last five decades. It was supposed that the rural situation would portray a medical system based upon beliefs of mystical¹ cause of sickness, with corresponding techniques of treatment, and that the urban situation would present a system based upon non-mystical or natural² beliefs.

A number of Sudanese colleagues, including social anthropologists and practitioners of modern medicine, as well as scholars of Darfur studies, saw the suggested model as a reasonable possibility. However,

1. Mystical - non-verifiable, supra-sensible.

2. Natural - observable or deducible by observations, not supra-sensible.
(See 'use of terms' p.viii)

the model has proved to be too simplistic. Beliefs of sickness cause are not necessarily correlated with the course of action taken in seeking treatment and also, beliefs of causation have necessitated a rather more complex classification than was originally envisaged.

1.3 REVIEW OF LITERATURE

A number of studies are to be found in the anthropological literature which are concerned with the explanation of sickness and other misfortune, and attempts to ameliorate the situation. However, there does seem to be a gap as far as studies of the medical system as a totality in a Muslim society, is concerned. It is hoped that this research may go some way towards remedying this situation.

In the course of preparing for research in Darfur, those works considered to be of general and specific relevance in the field of medical anthropology were studied and ethnographies of societies within the general geographical area were reviewed. The geographical area in which ethnographic accounts were sought, expanded from Sudan to include West, North and East Africa, the Horn of Africa and included a few examples from further south in Africa. Middle Eastern, particularly Muslim, societies at the eastern end of the Mediterranean and in the Arabian Peninsula were also studied. Although the Fūr are geographically within Africa, being Muslim and part of the Democratic Republic of Sudan, their culture looks naturally towards the Middle East; these two factors generally guided the choice of literature.

The list of ethnographic works reviewed for this study is long and is to be found in the bibliography. However, the reader will become

aware of the influence of the writings of Evans-Pritchard (1937) as he has analysed the way in which the Azande account for and cope with misfortune (including the misfortune of sickness). The Azande and Fūr have a number of common characteristics, it seems. They are both agriculturalists and have, in the past, been the subjects of a king and a ruling aristocratic class. Coincidentally, both the Avongara Azande King Gbudwe and the Kayra Fūr Sultan Ali Dinar were shot in minor skirmishes with the British (Gbudwe in 1905 and Ali Dinar in 1916), thus bringing both kingdoms under the rule of the Condominium government. For both peoples, this marked the end of an era, often referred to in narratives by older informants. The two societies are both patrilineal. A major difference between the two societies is, of course, the fact that the Fūr are Muslims, whereas the Azande are either Christians or followers of traditional religious beliefs. However, although it is some 300 years since the Fūr rulers and their courts became Muslims, it is probably only within living memory of the elderly Fūr that traditional religious practices were finally abandoned.¹

On reaching Darfur, it seemed that even more of Evans-Pritchard's description of the Azande fitted the Fūr, for the people are 'hospitable, good natured, and almost always cheerful and sociable'. They also 'adapt themselves without undue difficulty to new conditions of life ...' and are always willing to try new habits and practices, (Evans-Pritchard, 1937:13). A particularly noticeable feature of the Fūr character is their eagerness and willingness to experiment with 'modern ways' which may help to improve the quality of life.

1. See Chapter 2, pp.49-55 and the accounts of Beaton (1948), Arkell (1951) and Balfour-Paul (1955).

Realising, of course, that the Fūr as Muslims would be unlikely to be practising any kind of techniques of oracle manipulation (which is strictly prohibited in Islam), but knowing that beliefs in the evil eye (a type of witchcraft), sorcery, and magical powers did exist, it seemed reasonable to suppose that Fūr beliefs about sickness causation might be not too dissimilar from those of the Azande as portrayed by Evans-Pritchard.

In the study of non-Western medical systems, beliefs about the cause of sickness are culturally significant. Foster goes further and states that 'disease etiology is the key to cross-cultural comparison', (Foster, 1976:773), and acknowledges Glick's lead when he writes that 'the most important fact about illness in most medical systems is not the underlying pathological process but the underlying cause', (Foster 1976:774, referring to Glick 1967:36). Glick adds that diagnoses tend to be 'statements about causation' and that in the majority of cases, treatments are 'directed against particular causal agents', (*ibid.*). Thus, any study of a medical system should have as its central task or as one of its crucial investigations, the study of the cause of sickness.

Glick's paper, 'Medicine as an Ethnographic Category', points out that beliefs and practices related to sickness are generally within the sphere of and closely connected to religious beliefs and practices; in these cultures, a variety of mystical beings are commonly said to be the cause of sickness and healing usually involves symbolic ritual, aimed at the manipulation of the causal agents, (Glick, 1967:32-34). Glick is seeking an idea around which the specialized ethnographic information concerning medical systems can be organized - a comprehensive idea which

will not suffer from being culture-bound. He suggests the concept of power. Around such a concept, ethnographic material could be organized in order to make it potentially comparable and it would have specific relevance in the study of medical systems, (ibid.). When dealing with power, questions may be categorized under two main headings, according to Glick, - locus and control - and in the case of the medical system, enquiry into these two factors will yield information corresponding to that which would be incorporated by the terms 'diagnosis' and 'treatment'. 'A diagnosis involves ideas about sources of disease-causing power, and treatment involves attempts to overcome that power', (Glick, 1967:32-34). As will become apparent later in the thesis, human ability to control or overcome the 'disease-causing power' is central to the classification of sickness cause.

The study of Fūr concepts of the cause of sickness is a primary concern of this thesis, as has been indicated in the aims of the research. The literature on the subject of traditional medical systems, which is reviewed below, is only a part of that available and is restricted to African and Middle Eastern studies.

In the literature concerning traditional medical systems, particularly those in African societies, there is a much greater emphasis placed upon mystical explanations of sickness cause than upon natural explanations. This, presumably, is due to the fact that many of the therapeutic practices studied have been those connected with and practised for people who are suffering what would be diagnosed as mental illness by psychiatrists in the field of modern medicine. Such therapies

often consist of elaborate ritual and contain much symbolic meaning for the afflicted; they have been the subject of analysis by ethnographers and psychiatrists. Kiev's (1964) collection of papers marks the beginning of a concerted effort on the part of anthropologists and psychiatrists to gather together their varied material from all parts of the world where traditional therapies are used in the management of psychological disturbance. During the 1950's, Lambo published a number of papers on the treatment of psychiatric patients carried out at Aro, Abeokuta, Western Nigeria. These patients were treated in a village setting, with their own relatives caring for them, being hospitalized for periods when and if necessary. Prince (also a psychiatrist) has analysed the psychotherapeutic practices of Yoruba traditional healers, and Field, (another psychiatrist) has studied shrine visiting by the mentally sick in Ghana. However, while Lambo, Prince¹ and Kiev have been at pains to point out that they are discussing mental diseases rather than physical mal-functioning of the body in general, Field has not made such a distinction, and in her monograph states that 'According to African dogma sickness and health are ultimately of supernatural origin', (Field, 1960:112). Later, dealing with organic illness, she observes that this 'is almost always attributed to either witchcraft, bad medicine or sin', (ibid.117). This seems a rather sweeping generalization, and coming at a time of increasing interest in psychiatry and indigenous healers, may have helped to promote an assumption regarding the beliefs of Africans in general towards the cause of sickness.

1. For the several publications by Lambo and Prince, see Bibliography.

Spirit possession is another phenomenon which has attracted a number of analyses; it has been observed to be a world-wide phenomenon as Lewis (1971) shows, illustrating his theme with material from diverse cultures. Messing (1958), Barclay (1964), Kennedy (1967), Constantinides (1972 and 1977) and Crapanzano (1973) all deal with the phenomenon in various countries in the Muslim regions of Africa, viz. Ethiopia, Sudan, Egyptian Nubia, and Morocco. Reports of other non-natural phenomena such as the evil eye and jinns (spirits) as causes of sickness among Middle Eastern societies, are found in Lane (1895), Westermarck (1926), Blackman (1927), Walker (1934), Donaldson (1938), Granqvist (1950), Ammar (1954), Spooner (1970) and Gulick (1976).

Studies of African societies have tended to focus on the richness of ritual and symbolism in healing practices and ceremonial. The insight of anthropologists such as Turner (1967) and Ngubane (1977) have teased out the intricacies of complex diagnostic and therapeutic processes. Turner's interpretation of colour symbolism in the treatment of disease by the Ndembu, (Turner, 1967a), and the remedial process whereby the kin group of a victim of affliction is communally and corporately cured in the Ihamba ritual, following the diagnosis of a breakdown in social relationships by the cult adept, (Turner, 1967b), has added more weight to theories of mystical causation. Ngubane's analysis of Zulu health and sickness also relates cause and treatment to the family life of the individual and the social context in which they arise. Polluting women, the ancestors and sorcery are all agents of misfortune, which may manifest itself as sickness. Therapy may employ medicines

of different colours to regain the harmonic balance of the individual with his environment. Sensitive and painful issues are elevated to the realms of the mystical for resolution, thus freeing the actors from intolerable situations. (Ngubane 1977.)

The writings of Western-trained physicians working in Africa have also tended to emphasize the non-natural beliefs about sickness cause and treatment in their various publications: Harley (1970), working among the Mano of Liberia and Gelfand (1964) among the Shona of Rhodesia are examples.

After reviewing the social anthropological literature concerning communities in the geographical area (northern and eastern Africa and the Middle East), literature concerned with Islamic culture and also the medical anthropology literature, it seemed quite feasible that the Fūr would also lean towards explanations of sickness couched in mystical terms. On numerous occasions during discussions about sickness, key informants frequently referred to and affirmed the belief in mystical factors as cause in their explanations, thus encouraging one to consider this supposition to be reasonable. However, further interviews with ordinary Fūr farming folk and the responses to the questionnaire were to dispel any thoughts of drawing conclusions parallel to those previously drawn for African peoples.

Opportunity then arose, on a visit to Khartoum, to check some of the African and Middle Eastern literature again and to read further. A number of ethnographers do, in fact refer to beliefs in the natural causation of sickness by the peoples they have studied, although these beliefs have hardly been analysed; in most cases the references to them

are in passing, often in relation to other misfortunes, and are not elaborated.

Among Muslim peoples there is the transcendent belief that sickness and health are determined ultimately by the will of God, but apart from this, most individuals identify a more immediate cause. A study of concepts of the body and health care (Morsy, 1980a) in an Egyptian village, reveals that weakness due to malnutrition is often diagnosed as the cause of female infertility, while backache, headache and emotional distress are commonly associated with the menstrual cycle by the women who so suffer. Poor eyesight, too, is linked to a limited flow of (impure) menstrual blood. In general, a good diet, i.e. one containing plenty of meat and dairy produce (according to the poor Egyptian peasants of the study), is essential for good health. Much sickness is, however, regarded as being due to mystical phenomena, such as spirit intrusion, the evil eye and sorcery, although it would appear that sociological factors may affect explanation, (Morsy, 1980a:94).

In Morocco, Crapanzano (1973) notes the two categories into which sickness cause may be divided; he terms them 'naturalistic' and 'preternaturalistic'. The naturalistic factors are found in such sicknesses as tuberculosis (caused by cycling without a shirt, especially on hot days), certain heart troubles (caused by eating salt), syphilis (caused by contact with menstrual blood) and gonorrhoea (believed to be due to the reflux of semen into the kidneys if not washed out by urination immediately following intercourse), (Crapanzano, 1973:134).

Of the Somali, Lewis records that 'illness is very rarely ascribed to magical causes. Nor is it necessarily a direct and specific reflection

of the wrath of God', (Lewis, 1963:259). As man is believed to be sinful by nature, if sickness and misfortune were the punishments, he would be suffering one or the other continuously, and this is not the case. 'Neither divine retribution nor sorcery provides a regular idiom of immediate causation, and witchcraft exists only in a few special contexts', (*ibid.*). Lewis found the Somalis to be 'eminently practical' concerning the explanations of various practices, such as the use of certain plants in medicines - they are tried and tested remedies - and the abstinence from sexual relations before a battle or a raid - they are exhausting. Despite being a 'highly pragmatic' people, the Somalis do, apparently allow for the mystical power of religious leaders (Ar. *shayks*) and saints (*ibid.*:26) and utilize an abundance of mystical prophylactic techniques in their precarious pastoral existence, (*ibid.*:258).

According to Buxton, while Mandari explain many episodes of sickness mystically, there are a number in which they are aware of natural causes, especially when the symptoms are neither prolonged nor violent, such as many childhood complaints, (Buxton, 1973:322-3). However, it appears that 'common sense' explanations may always be overtaken by mystical ones in serious sickness, (Buxton, 1973:365). In her conclusion Buxton points out that Evans-Pritchard, in his analysis of mystical thought and belief, has also given consideration to natural or 'common sense' judgements of cause. She quotes from a paper on Lévy-Bruhl's theory of Primitive Mentality - 'at the core of mystical thought we find recognition of natural causation...' (Evans-Pritchard, 1933).¹ Of the Azande Evans-Pritchard also writes, 'The Zande accepts a

1. Quoted by Buxton 1973:415. In a footnote (*ibid.*) she refers to Evans-Pritchard's paper which is on Lévy Bruhl's 'Theory of Primitive Mentality', The Bulletin of the Faculty of Arts (Cairo), Vol.2, Part (i) (1933).

mystical explanation of the causes of misfortune, sickness and death, but he does not allow this explanation if it conflicts with social exigencies expressed in law and morals', (Evans-Pritchard, 1937:75).

A paper by Gillies (1976) strikes a note of caution with regard to accounts of sickness causation which, she maintains, 'have not taken sufficient note of discriminations made by the actors, both between different kinds of illness and between levels of aetiology and pathogenesis', (Gillies, 1976:358). The concept of levels of cause seems to be one which has been developed mainly by students of Central American communities and I refer below to Douglas's (1969) and Cosminsky's (1977) research. However, among students of African societies Ngubane (1977) describes Zulu theories of natural causation as having two levels of operation: one where sickness 'just happens' and the other where cosmology governs ecological influences, (Ngubane, 1977:22-24). Ideas associated with Nature, of the second level of causation, are often bound up with pollution and of 'stepping over' dangerous tracks or substances, (Ngubane, 1977:25-29). In the classification used in this study, the second level of causation used by the Zulu would be regarded as having mystical overtones.

After returning from the field, a paper by Cosminsky (1977) was encountered, in which she classifies the results of her research into 'Illness Concepts among a Mayan Guatemalan Community'. Referring to Douglas (1969) who also studied illness and curing in a Mayan Guatemalan community, Cosminsky has adapted a model for classifying causes of sickness. The main categories offered by the model are those of external

factors which are outside human control and internal factors which increase individual susceptibility, being generally within human control, or where human control is a possibility. Factors relating to environmental conditions and mystical agents comprize the external category; factors affecting the human physical and mental state, and social and ritual conduct comprize the internal category. As with Zulu theories of causation, there are then two levels of operation of cause (below the ultimate level of the Deity) - the first immediate level involves natural, common sense factors; the second, intermediate level involves mystical factors relating to religious and social values.

At this time also, my attention was drawn to the work of Warren (1979) and his analysis of Techiman-Bono classification of sickness, where the majority of causes are defined in natural terms. This, however, is contrary to the earlier findings of Field (1960) who studied in the same general area. In Warren's view, Field has 'missed the larger portion of the Bono disease classification system, that dealing with naturally-caused diseases', (Warren, 1979:36).

Numerous other works have contributed to the background reading for the present study, several of which have been published since the fieldwork began. Janzen's study of the BaKongo of Lower Zaire (1978) provides a 'holistic' study of the medical system and notes specifically that traditional healing has not disappeared. Rather, the two forms of healing have developed into a system of complementary alternatives. A central issue in the BaKongo study is the 'therapy managing group' which, as Janzen notes (Janzen, 1978:7) has not received any extensive analysis in the literature. Most studies have focussed on the healer and the

rituals of the healing process, ignoring the numerous kinfolk who normally accompany any sick individual in seeking treatment. BaKongo, it should be noted, also make a distinction between what they call 'illness of God' (one that is natural in cause) and 'illness of man' (which entails conflict in social relationships), (ibid.:8-9). Janzen's work provides a comparative study for the Fūr material concerning social change and the medical system.

Another work of particular relevance in social change is that of Brokensha (1966), who shows how 'old and new forms have blended, achieving accommodation in nearly all areas of social life' (Brokensha, 1966:269). 'Adaptation' and 'accommodation' are the key words in Brokensha's analysis of the social change at Larteh, Ghana (ibid.) and they would seem to be fitting in a description of social change in a society, like that of the Fūr, which has witnessed a remarkable degree of change over the centuries, with an increase in intensity in the last 50 years.

As far as the Darfur Sultanate is concerned, O'Fahey is the contemporary historian and he has several publications, covering early historical traditions through to the final days of the sultanate, (O'Fahey and Spaulding, 1974; O'Fahey, 1972; 1973; 1979; 1980). O'Fahey's work is rich in insight into the social life of the Fūr people and that of the Sultan and his court.

Arke11 (1951; 1952), Nachtigal (1971), Lampen (1950), Macmichael (1922), and al-Tunisi (1854, in translation), have formed the main reference works after O'Fahey. As far as the geographical and ecological

background is concerned, Barbour (1961) provides much information for the general area. Adams (1975; 1980) and Adams and Hales (1979) analyse the particular problems of subsistence agriculture and pastoralism in Southern Darfur. Papers by Barth (1964; 1967; 1975) and by Haaland (1969; 1972) Holý's (1974) monograph on the Fūr neighbours, the Berti, accounts by Cunnison (1966) of the Baggara and by Asad (1970) of the Kababish Arabs, and the thesis of Musa Abdel-Jalil (1980) concerning ethnic identity in Northern Darfur, have all provided sociological background to the general area of Darfur.

1.4 THE RESEARCH SETTING

Following discussion with Professor Abbas Ahmed of the Department of Sociology and Social Anthropology University of Khartoum before embarking upon research, it was decided that fieldwork should be carried out among the Fūr of western Sudan. This choice was based upon several factors:

- (i) it is known that practitioners of country medicine are numerous in the area;
- (ii) in recent years the Ministry of Health of the Democratic Republic of Sudan has been training a new grade of practitioner of modern medicine (the community health worker) who is rurally based;
- (iii) the area is generally rural, some communities being very remote while others are relatively urbanized; there is an agricultural and pastoral development project in the region, which means that social change is very much a feature of Fūr life and will be so for the foreseeable future;
- (iv) the Fūr have been little studied by social anthropologists, except with regard to their economy (Barth, 1967 and Haaland, 1969; 1972) and their music and women singers (Carlisle, 1973), although the work of O'Fahey in tracing the history of the sultanate, gives many insights into social life up until the demise of Ali Dinar in 1916.

Darfur is situated at one of the cross-roads of Africa. For centuries, there have been trade routes going north to the Maghrib, north-east to Egypt and west to Kanem-Bornu, along which merchants have travelled with their caravans of camels. There is also an east-west trade route between West Africa and the Saudi Arabian peninsula, but this route is used primarily by pilgrims to the holy places of the Hejaz. To the south of the Darfur Sultanate is a region which suffered much at the hands of slave raiders (notably Zubayr Pasha) who then transported their miserable captives through Darfur towards the north and Egypt, where thousands were sold in the market places. However, only a handful of travellers from outside Africa and the Middle East are recorded as having passed through Darfur.

The majority of Fūr, it seems, were anti-Mahdists. At least, they were not prepared to be involved to any great extent in the revolution which took place at the end of the nineteenth century (O'Fahey and Spaulding, 1974:186). Following this came the Anglo-Egyptian Condominium Government and a period of direct, followed by indirect, rule. At this time (from 1922 onwards), the Condominium government attempted to isolate the inhabitants of Darfur from knowledge of the more developed areas by restricting travel to the region in order to hinder the spread of new ideas and to prevent religiously inspired uprisings.¹ With Independence (1956) came the freedom to travel throughout Sudan once more, and at the same time many Fūr men began to seek work in the

1. Darfur was made a 'closed district' by the Passports and Permits Ordinance, 1922, chapter 4: Closed Districts. (The Revised Edition of the Laws of the Sudan from 1899-1926).

developing farming region, the Gezira, as well as in Khartoum.

Gradually Darfurians developed a consciousness about the comparative lack of development of their region.

Historical events have divided Darfur's contact with the outside world into three major periods:

- (i) the centuries before the Condominium government when travel, trade and pilgrimage could occur unhindered, although contact was limited to that with other parts of Africa and the Middle East;
- (ii) the period of the Condominium when outside contact was reduced to a negligible degree, pilgrims and traders being discouraged by the institution of a permit fee; and
- (iii) the present period, since Independence, when the modern beliefs and practices of the Western world have been disseminated (in varying degrees) throughout Sudan, even to the remotest villages.

The Fūr are hoe agriculturists, inhabiting the more fertile areas of what used to be the heartlands of the Sultanate of Darfur, the central massif of Jebel Marra and the lowlands to the south-west of the mountain, see map 3. p.94. This mountain rises from the centre of what is today the Region of Darfur. To the north lies desert and to the south, savanna grasslands. Darfur is geographically and practically remote from the capital of Sudan and is only accessible with difficulty. The Fūr manage to subsist through their relatively simple technology in villages which tend to be situated in the most fertile areas of the region. In the mountain region and along the banks of seasonal rivers villages are small but in larger market villages, the Fūr are joined by other ethnic groups. In several neighbourhoods of the small market town of Zalingie there are Fūr majorities.

Arabic is spoken by almost all men in Darfur and by a majority of women too. Most adult Fūr, however, also retain their own language, especially in the more remote villages. In some of these villages, the majority of women understand only a little and speak few words of Arabic but men are usually bi-lingual. Other ethnic groups also have their own languages, but like the Fūr language, these seem to be gradually being replaced by Arabic. The Fūr language is regarded by Greenberg as being unrelated to other African languages (Greenberg, 1955:96).

Nowadays all Fūr are Muslims. Conversion to Islam was apparently a gradual process, beginning in the time of Sultan Sulayman Solong in the mid-17th century. Within the life-time of elderly informants, many non-Islamic ritual practices - notably public communal rituals for seasonal agricultural fertility and the symbolic drums, and cults devoted to snakes - could still be witnessed in Darfur.

Growing up in Darfur involves every boy in becoming a student of the Qur'an and travelling from one teacher to another in order to be able to read, recite and write all or part of the Book. Girls also join Qur'an classes in the mountain villages for a number of years but they do not travel away from home. However, knowledge obtained in this way (by rote learning) can give little more than a superficial acquaintance with the faith. As few Darfurians have had the opportunity to study at one of the more formal religious institutions, their understanding of Islam must necessarily be somewhat restricted.

Islam was brought to Darfur by itinerant holy men who were encouraged by successive sultans. The majority of these holy men were members of

sufi (Ar), mystic, brotherhoods. However, it seems that it was not the companionship and solidarity of the brotherhoods that attracted the people of Darfur, but, rather, the personal charisma of the holy men themselves and their reputed magical and miraculous deeds. Islam has 'embraced the widest variety of races' (Gibb, 1975:15) and religious beliefs, adapting and accommodating to assimilate them in an 'ultimate synthesis', (Trimingham, 1980:44). Thus, almost certainly, some of the ancient traditions of the Fūr would have been assimilated into the newfound faith.

Among the Fūr, and in Darfur generally, traditional beliefs and practices in the field of sickness and healing are very evident. Every community has its practitioners of medicine, such as women who have a few tried and trusted family remedies and who treat members of their extended family, and healer-teachers (feqis) who use the holy word in one form or another in their therapeutic practice. Within an area, a number of other specialists are also likely to be found, such as bone-setters, midwives and herbalists. Thus, within a ten to fifteen kilometre radius, a number of different healers could be consulted without too much difficulty.

Fūr healers are renowned throughout Sudan as being particularly powerful but among the Fūr themselves, it is those coming from further west, or whose families originally came from West Africa, who have this reputation. Healers from West Africa often take up residence in Darfur while going to Mecca and some do so on the return journey. Some have stayed for years, others for two or three generations and have settled: they are known in Darfur (and throughout Sudan) as Fellata.

Feqis are the most significant healers. They are general practitioners and normally would try to give assistance in any episode of sickness. They also specialize in attempting to alleviate problems which are believed to be due to sorcery, the evil eye and the machinations of spirits. Other practitioners tend to be rather more limited in their scope by the very nature of their specialization, bone-setters, eye specialists and rope-midwives¹ being examples. Herbalists have a wider range of therapies and include digestive disturbances, skin problems and fevers among their repertoire of treatable symptoms. There are also a few practitioners who have added the techniques of other specialists to their repertoire; there are feqis who also use plant materials and have some knowledge of bone-setting and herbablists who may also use some holy words in their treatments (they have all learnt to recite the Qur'an to some extent); it is not necessary to be a feqi to use the words of the Book, any Muslim can do so. The Fūr are confident in their beliefs about the curative value of verses from the Qur'an and other religious books used in healing. They, apparently, do not practise any other techniques involving mystical features, although it is just such supposed mystical practices which have gained them their reputation as powerful healers. It is believed that Fūr feqis have the ability to transmogrify (changing themselves into animals, usually tigers or leopards), and to cause inanimate objects to move, apparently of their own accord. Among the Fūr, such a reputation is accorded the Tāma and Fellata peoples. Of

1. Rope-midwife - (dayat el-ḥabil) named after the rope (ḥabil) she hangs from the roof of the cottage for the woman to support herself while giving birth, in a squatting position.

the practitioners encountered, only one claimed such powers himself but, after promising to exhibit his powers, eventually excused himself.

Modern medicine is another, highly regarded, alternative therapy for the Fūr, adding extra dimension to therapeutic practice. Medical science also offers new and acceptable ways of explaining the cause of sickness.

The people of the more remote areas of Sudan, of which Darfur is one, are gaining access to varying degrees of modern medicine via a network of small dressing stations and primary health care units, dispensaries, district and provincial hospitals. These are staffed by general medical practitioners, physicians, surgeons and medical assistants, supported by nurses and members of the paramedical professions. People in remote areas can, in theory, be referred by a community health worker or nurse from the smallest health unit, on to a medical assistant at a dispensary and then on to consult a doctor in the provincial hospital and, if necessary, to a consultant specialist; in a few instances sick individuals have been flown to Khartoum for treatment unavailable in Darfur, such as deep X-ray therapy for cancer.

Although modern medicine was introduced into Darfur some fifty years ago and has rendered a number of previously fatal diseases preventable or curable by drug therapy (with smallpox officially eradicated), it was not until 1974 that an attempt was made to bring even a very basic form of rural medical care to the remote villages and the nomadic peoples of Sudan. The decision taken by the government of Sudan was coincident with that taken by UNICEF to bring aid to mothers and children of the low income countries. The WHO/UNICEF Alma-Ata conference, 1978, then took

as its aim 'Health for All by the year 2000', and 'primary health care' was launched. In Sudan, 'primary health care' means the 'absolute minimum commensurate with effective treatment' and the emphasis is on prevention,¹ (Matheson, 1981:3). The primary health care plan is designed to bring local communities in to participate in the establishment and running of the primary health care units, and young people from the rural communities have been encouraged to train as community health workers.

The Fūr have been keen to co-operate with modern medical personnel to establish the primary health care units. They have built some of the small clinics necessary and have encouraged their sons and daughters to train as community health workers and midwives respectively. After their training, these young people then return to their own villages and form the nucleus of the primary health care service. Along with an expansion of the services of modern medicine, the Fūr are hoping for increased facilities for education and communication, all of which, they believe will improve the quality of life.

1.5 METHODOLOGY

In order to gain a picture of both the rural and urban settings of life in Darfur, as well as of the system of medicine, it was decided to carry out research in two somewhat different communities - a fairly remote mountain village and a Fūr neighbourhood in the small market town which forms the administrative centre for the district. The village is some distance from the nearest centre of modern medicine, which is a

1. In practice, the emphasis is on curative medicine, see Chapter 9.

TIME	FIELDWORK LOCATION	FIELDWORK ACTIVITY
1978		
Aug		Administrative details: visa, permits, letters of introduction
Sep	Khartoum	Library research - Sudan Library, Public Records Office
Oct		Visiting Fūr living in Khartoum and practitioners of medicine (Fūr and other)
Nov	Travelling: El-Fasher/Nyala/ J.Marra/Zalingie	Assessing suitable fieldwork locations Pilot testing of questionnaire
Dec		
1979		
Jan		
Feb	Zalingie/ Azumiya	Participant observation; interviewing; selecting of urban community; pilot testing of questionnaire continued
Mar		
Apr		
May		
Jun	Jebel Marra/ Barei	Participant observation; interviewing
Jul		
Aug		Participant observation and interviewing continued;
Sep	Zalingie/ Azumiya	finalizing form of questionnaire and printing it;
Oct		administration of questionnaire
Nov	Jebel Marra/ Barei	Participant observation and interviewing contd.; administration of questionnaire
Dec		
1980	Khartoum	
Jan		
Feb	UK/ Edinburgh	Initial organization of data; programming for next field trip
Mar		
Apr	Khartoum	Administrative details
May	Jebel Marra/ Barei	Participant observation and interviewing continued
Jun		
Jul	Khartoum	
	UK/ Edinburgh	Writing up

Table 1a: Chronology of Fieldwork

TIME	FIELDWORK LOCATION	SEASON	FARMING ACTIVITY	
			rainfed crops	irrigated crops
1978				
Aug		RAINS	x	
Sep	Khartoum		x	
Oct			x	
Nov	<u>Travelling:</u> <u>El-Fasher/Nyala/</u> <u>J.Marra/Zalingie</u>	DRY		*
Dec				
1979				
Jan		DRY		
Feb	Zalingie/			
Mar	Azumiya			
Apr		RAINS	x	*
May			x	
Jun	<u>Jebel Marra/</u> <u>Barei</u>		x	
Jul		RAINS		
Aug	Zalingie/			
Sep	Azumiya		x	
Oct		DRY	x	
Nov	<u>Jebel Marra/</u> <u>Barei</u>			*
Dec	<u>Khartoum</u>			
1980		DRY		
Jan				
Feb	UK/			
Mar	Edinburgh	RAINS		
Apr	<u>Khartoum</u>			
May	<u>Jebel Marra/</u> <u>Barei</u>		x	*
Jun		RAINS	x	
Jul	<u>Khartoum</u> <u>UK/</u> <u>Edinburgh</u>		x	

x = busy farming time

Table 1b: Chronology of Fieldwork and Seasonal Farming Activities

dressings station run by a community health worker; the urban neighbourhood is situated literally on the doorstep of the district hospital.

A total of some 17 months was spent in Darfur, during which time many informants, including healers, both Fūr and non-Fūr, were encountered and interviewed. They proved to be extremely helpful and interested informants. Some time was spent in each of the two main towns of the region, el-Fasher and Nyala, on several occasions and informants were visited there a number of times. The greatest stretch of time was spent in Zalingie town and particularly in the neighbourhood of Azumiya, where information was gathered by participant observation, interviews and also by the use of a survey schedule¹ which was designed to collect information about beliefs and practices during episodes of sickness. Similar techniques were used in Barei village which is high up in Jebel Marra, some five hours (about 20km/12 miles) trekking and climbing from the nearest market village with a fairly regular (once weekly in the dry season) lorry service.

Field assistants:

During the period of fieldwork several field assistants helped in the gathering of information, and as mediators and interpreters when necessary. Money was not available to pay a full-time assistant but in Zalingie a student nurse filled this role when he was off duty, and in Barei three brothers (two university students and a community health worker) divided

1. A copy of the survey schedule is to be found at the beginning of Part II of the thesis.

see also Tables 1a, 1b.

the role between them. In el-Fasher and Nyala another university student and two teachers were of great assistance. All these assistants were Fūr and came from local families. They were either well-known to the informants or related to them.

Although I became acquainted with enough of the Fūr language to understand much of the conversation taking place at interviews and could converse in colloquial Arabic, it proved to be more worthwhile to have the questions of the survey schedule asked by the field assistant - in Fūr or Arabic, whichever the informant preferred. This was particularly the case with female informants, who were reticent or given to much nervous giggling during interviews. Normally they are boisterous and talkative.

The mediating function of the field assistants proved to be as important as their interpreting. They introduced many practitioners of country medicine and other people of note in the communities. Sickness and healing tend to be rather sensitive subjects but the combination of kinship relations with informants and their own knowledge of modern medicine, enabled the field assistants to arrange meetings with retiring and secretive individuals, with religious men unused to conversing with women, and with grandmothers who would rather have been about their daily business. These assistants were also able to enquire into personal case histories, beliefs of causation of sickness and closely guarded therapeutic practices. The good relations enjoyed during fieldwork with practitioners of medicine and the ordinary inhabitants of Darfur, was due directly to these assistants.

Participant observation:

While living in the mountain village I was given a cottage in the homestead of the father of my field assistants. This was one of the original homesteads and the family is one of the more important in the area, being descended from the imams of Turra - whose forebear was invited by Sultan Musa Sulayman to come to Darfur to teach Islam. After the initial visits to important personages, people started visiting me - at first out of curiosity but later to impart information. Very quickly, the family members began to treat me similarly to the brothers on vacation from university. I was expected to go visiting with them and not to carry out household chores as a sister might have been. The women were always amused by my attempts at food preparation (grinding flour and stirring of the staple porridge), and interest in pot-making.

As occasional visitors to their natal home, my field assistants were always visiting their numerous relatives in the same village and in others not too far away. This meant that there was often a chance to enjoy the warmth and welcoming of Fūr family life and to witness the strength of kinship ties.

In Zalingie, where I arrived without a mediator, the search for accommodation in the neighbourhood of fieldwork could not take place immediately as the neighbourhood had still to be chosen. However, a room in one of the houses attached to the hospital, with meals provided by a local cook, proved to be suitable. As far as the fieldwork was concerned this house had the advantage of having electricity for three hours a night (while supplies of fuel lasted), and the cook was well-known and became a very good friend, companion on visits to the market,

teacher of colloquial Arabic and, occasionally, informant.

This choice of accommodation proved to be fortuitous because the hospital was situated next to one of the predominately Fūr neighbourhoods of Zalingie, which was eventually chosen for the administration of the survey schedule. Also, it meant that I was regularly seen in and around the hospital as well as in the market place and other parts of the town. Although it was generally known that I was not a doctor, my interest in and familiarity with the field of medicine and health care was apparent, as was my interest in indigenous medical beliefs and practices by my constant questioning of healers and lay people.

Practitioners of country medicine who were initially reluctant to be interviewed, often expressed interest in knowing why someone should come from such a distance to visit them. After being convinced that my motives in research were honourable, they became keen to talk about their methods of healing, so that others far away might learn about them. They are proud of their therapies. Although the majority of individuals encountered, have experienced or witnessed the results of modern medicine, they feel strongly that both country and modern medicine have their places in the treatment of sickness today in Darfur.

Problems of fieldwork:

Women carrying out fieldwork in remote areas expect, and usually experience, some difficulties. This may be just because they are women or as a result of being in a totally different society with expectations and values at variance with those of their own society and culture.

These problems have been arranged into the following five categories by Golde (1970:5): protection, initial suspicion, conformity, reciprocity and culture shock, and as such provide valuable preliminaries.

Protection began before the fieldwork started, with letters of introduction to the friends and relatives of a Sudanese colleague. These people were warm, friendly and always welcoming, a feature I have found to be generally characteristic of Sudanese people in their relationships with foreigners. Local government officials provided transport on a number of occasions and smoothed the way for meeting people. My various field assistants, the families I stayed with on short visits to other villages, my adopted family in Barei and many other people all offered a measure of protection which was always kindly and never claustrophobic. The odd encounters with sexual overtones were inevitable in the capital, where occasionally one had to negotiate officialdom without an escort. Extrication was usually accomplished without too much loss of face by being accompanied by a friend on subsequent occasions.

Initial suspicion was an expected feature but one which was seldom exhibited, except when visits were made to isolated villages where no introduction was available. My introductory letters and the fact that the first visit to Barei was made in the company of one field assistant, minimized suspicion as to my presence and motives in visiting, although I was the first white woman many of the people had seen.

This brings one to the subject of conformity. Women in Darfur and Fūr women in particular, are very independant when compared with their

counterparts in other parts of Sudan. They take an equal part in farming activities and are used to having their say in most matters. There is little segregation in rural homesteads and farming activities preclude any while working. Thus, the idea of a woman apparently not dependent on a man, was not so peculiar to them, though my lack of children (firstly) and husband (secondly) did raise a few questions to begin with. Concern was often expressed for my parents, who had allowed me to travel so far away from home and must, therefore, be very worried.

Conformity was intentional in the matter of dress. Long colourful adaptations of the male jellabiya (a flowing white, dress-like garment) provided figure-disguising outfits in line with Islamic modesty on all occasions. The diaphanous tōb (sari-like wrapper worn by women) is too unruly for walking and travelling by the inexperienced and also makes the European wearer a focus of attention.

Living in the 'mess' situation in Zalingie, at the hospital, did not result in as many 'raised eyebrows' as one might have expected - at least I felt no repercussions if they were raised. The presence of the female cook and, for a time, that of the European wife of one of the medical officers, may have allayed suspicions.

Reciprocity posed quite a problem because there was no chance to fully pay for my board and lodging, let alone to return the numerous kindnesses of so many people. As sugar is a necessity of life in Darfur (and Sudan in general), where tea is taken with three to five spoons of sugar, and is relatively expensive, it was decided to give this commodity whenever and wherever possible. Lengths of material for men's jellabiyas

and women's dresses, and the occasional tōb were given on other occasions. People in general enjoyed having a copy of their photograph. Many of the villagers of Jebel Marra had never seen a photograph before, so this was a constant source of enjoyment. Photographs were displayed in the houses and shown to all visitors. (The majority of people were keen to be photographed, a few fegis refused and occasionally a few women covered their faces when they realised they were in view, though not the subject of the picture. Permission was always asked before photographing an individual as a subject.)

Culture shock was not great on arrival and settling down in Darfur, as this was not my first experience in an African or a Muslim country. Frustration, anxiety and depression were very occasional and short-lived, possibly because they were foreseeable and measures could be taken in an attempt to forestall or counter these emotions. Talking to a friend, listening to the Overseas Service on the radio - particularly to programmes of classical music - and taking an early night, all helped in the maintenance of some order of normality during the times when a feeling of dislocation was present. My paramedical training and previous time spent in other cultures were very beneficial, I feel, in adjusting and accommodating to the fieldwork situation. (The time when I suffered a culture shock was when I returned to Khartoum after a period of about a year in Darfur and could not adjust to traffic, city noises and crowds of people for several days.)

The survey:

A questionnaire was used in a structured interview situation, to enquire into beliefs and practices concerned with sickness. The survey was

carried out in a neighbourhood of Zalingie town, some nine months after arriving in the field and in a remote mountain village two months later. Small pilot studies were carried out in el-Fasher and Zalingie, among Fūr informants, before finalizing the form of the questionnaire and printing it. In the pilot studies, as in the two full studies, the questionnaires were administered by Fūr field assistants, accompanied by myself.

In both areas it was decided to make an outside limit of 100 interviews (50 women and 50 men, chosen at random by household) due to the limited availability of field assistants, who were university students on vacation and fairly busy practitioners of modern medicine (a nurse and a health worker).

The survey schedule was divided into four sections: section I seeking to gather biographical details; section II enquiring into peoples' beliefs about sickness in general and the action they would take if (in the hypothetical case) either they or their children became sick; section III seeking information about beliefs and actions concerning a past episode of sickness; section IV being designed to interview an informant who was sick at the time, enquiring into beliefs and actions associated with the prevailing condition.

The survey questionnaire is shown in full at the beginning of Part II of the thesis and will be discussed more fully there.

Individual interviews:

During the course of the field research, 68 practitioners of country medicine were interviewed with regard to their techniques of treatment,

beliefs of causation of sickness and their careers as healers. Some thirty individuals who were connected with the practice of modern medicine, from medical officers and administrators to pharmacists and public health personnel, were also interviewed about specific problems or points of interest but not in the same detail as the practitioners of country medicine. Other individuals of importance in the communities were interviewed at length and are regarded as key informants. They were either seen on a regular basis and gave assistance as necessary or less frequently and for a lengthy interview.

1.6 SYNOPSIS OF THESIS

This thesis falls naturally into three Parts: Part 1 is generally ethnographic, Part 2 deals with sickness and the practice of medicine and Part 3 examines social change and the possible ways in which anthropological research can be used in the planning and development of health services.

Part 1 comprises Chapters 1-4. Chapter 1 is the introduction, Chapter 2 is essentially historical and records the rise and fall of the Sultanate of Darfur, the influence of Islam on various aspects of social life and the medical system and the influence of contact with the outside world, through pilgrimage, trade, labour migration and education on health and medicine. More recently, developments in Sudan have meant the disappearance of much epidemic disease and the growth of international interest in the development of agricultural resources, while endeavouring to prevent exhaustion of the land by overgrazing.

Chapter 3 is intended to set the Fūr into their geographical and social environments. Their neighbours are depicted, local government is briefly discussed and the social organization of Fūr life is examined by its institutions, most of which follow the broad outline of the Islamic way of life. Chapter 4 looks at the everyday life of the Fūr in a remote mountain village and in the neighbourhood of a small market town. Seasonal and day-to-day activities are described, along with certain customs which are related to major events in Fūr life.

Part 2 comprises Chapters 5-7. In Chapter 5 Fūr concepts of sickness are analysed with reference to material collected through formal interviews, informal discussion and a survey questionnaire. Chapter 6 is concerned with the practicalities of how the Fūr deal with sickness - the conduct of the sick and that of their kin and neighbours in the therapeutic milieu, where they constitute the caring group, was witnessed during normal participant observation and was supplemented by interviews, discussion and the responses to the questionnaire. This chapter concludes with two short illustrations of visits by two sick individuals to practitioners of medicine - one to a country practitioner, a well-known and respected feqi, and one to a practitioner of modern medicine working in a small hospital.

Chapter 7 is devoted to detailed studies of each type of practitioner of medicine encountered in Darfur, with biographical details to illustrate each type of practitioner-career, followed by descriptions of the various therapeutic techniques and skills of the practitioners.

Part 3 of the thesis comprises Chapters 8-10. Chapter 8 outlines social change which has taken place in Darfur with regard to the medical

system. Historical, environmental, political and economic factors are studied somewhat briefly and then a section on change in disease pattern provides the background for the following sections concerning changes in beliefs about causation of and response to sickness. These changes are illustrated wherever possible by comparison of the situation in the rural and urban communities. It is assumed that urban life would have been responsible for changes in beliefs and practice, as would proximity to a hospital, a supply of modern medical drugs (however erratic) and greater opportunities for education and self-information on an informal basis. The presence of modern medicine in a community may well determine aspects of social change as it offers a specialized training and occupation to those individuals who have reached the necessary standards of formal education. By its very presence, modern medicine begins to educate people by example of its practitioners.

In Chapter 9 an outline is given of the ways in which a social anthropological study of small-scale communities can be of use in the determination of appropriate technological development, - in this case for the health service. Chapter 10 forms the conclusion.

In his essay The Gift, Marcel Mauss (1954) has emphasized the necessity to understand '"total" social phenomena', for only then is it possible to 'see their essence, their operation and their living aspect, and to catch the fleeting moment when the society and its members take emotional stock of themselves and their situation as regards others.'

(Mauss, 1954:77-78.) The aim of this research then, acknowledging Mauss's recommendation, is to study a system of medical beliefs and practices in its 'totality', in order to make a contribution to our knowledge of sickness and healing in Muslim communities and also to indicate how such research can be of benefit to those communities when the decision is taken to 'develop' them.

Chapter 2

DARFUR: HISTORY AND CONTACT WITH THE OUTSIDE WORLD

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2.1 INTRODUCTION

In order to understand the medical system of Darfur today, and in particular that of the Fūr people, it is necessary to gain insight into the history of Darfur as a divine kingdom, an Islamic sultanate and now as a region of the Sudan Republic. Changes in medical belief and practice have not always kept pace with socio-economic changes and this has had an effect upon the medical system. Several factors, such as conversion to Islam, aspects of Islamic medicine, pilgrimage to Mecca, trade, labour migration and education have had direct consequences on Fūr social life and specifically upon medical belief and practice, and the health of the community.

2.2 EARLY HISTORICAL TRADITIONS

The position of Darfur, to the south of the Sahara, has been conducive to contact with the Mediterranean, West African, Nilotic and Egyptian Islamic cultures over many centuries. The rough stone barrows in Northern Darfur are said by the Fūr to be the graves of the Tora people who are credited with the innovation of terrace-cultivation and with irrigation by streams, which used to flow perennially in Jebel Marra until recently.¹

1. See Balfour-Paul (1955) for further detail about the Tora and their buildings of dry-stone walling. See Appendix 1 also.

Historians of Darfur generally agree that three dynasties ruled in the region, the Daju, the Tunjur and the Kayra. The Kayra is the most recent and much is known about these rulers. They formed an élite lineage of the aristocratic Kunjara clan of the Fūr. The first Fūr ruler is believed to have been Daali (or Dali) and before him, the last Tunjur ruler was Shau Dorshid. Their relationship is unclear and the stories which link them also include the name of Ahmed el-Ma^Cqur, the 'Wise Stranger', who encounters a remote and uncultured people, introduces new and refined customs (in association with food and hygiene), marries the daughter/sister/former wife of the ruler and begins a new dynasty. Such stories are many and varied in the Sudanic belt of Africa. Anyway, as Balfour-Paul poetically remarks,

'...across this misty horizon run the intriguing but mysterious figures of Shau Dorshid, Dali the Lawgiver, Ahmed el-Ma'gur ('the hamstrung') and Suleiman Solong ('the arab')'

Balfour-Paul (1955:8)

From collected traditions and more recent histories, it is possible to find a number of points in general agreement: it seems that the Daju were immigrants, perhaps from the east, they settled in the southern part of Darfur; the Tunjur may also have come from the east, and settled in the north of Darfur, enjoying a 'short but grandiose' imperial career (O'Fahey and Spauling 1974:110); the Fūr expanded their kingdom from their mountain stronghold in Jebel Marra and superceded the Tunjur; all three kingdoms were ruled by autocratic monarchs, were centrally organized around their king, with hierarchies of slaves and freemen; during the reign of Sulayman Solong, Islam came to be regarded as the state religion although conversion had begun long before, (Nachtigal, 1971:275; Balfour-Paul, 1955:8-9).

2.3 THE KAYRA SULTANATE

The royal Kayra lineage of the Fūr must have begun to show itself as a leading and uniting force in Jebel Marra in the 16th century. By the middle of the 17th century, Sulayman Solong had established himself as an extremely strong ruler. Sulayman is believed to have had a Kayra mother and an Arab father and to be possibly the eighth ruler after the legendary Daali. Sulayman is credited with uniting the Fūr and non-Fūr peoples of Jebel Marra and the surrounding districts and subduing the region as a whole. During his reign Darfur was trading with Egypt on a large scale.

Following Sulayman there were ten sultans until 1875, when a number of 'shadow sultans' ruled from Jebel Marra until 1898. Ali Dinar, grandson of one of the previous sultans, declared himself Sultan in 1898. Ali Dinar was killed by British soldiers while resisting the take-over of his kingdom in 1916.¹

2.4 MORE RECENT EVENTS

After its annexation to the Anglo-Egyptian Condominium, government centres were set up at el-Fasher, Kutum, Um Keddada, Geneina, Nyala and Zalingie, with a British District Commissioner appointed to each to head the local hierarchy of hereditary officials. The British policy at this time was of Direct Rule and the District Commissioner was judge, administrator, chief surveyor and inspector of education. Following the publication

1. More details on the early historical traditions and the Kayra sultanate in Appendix 1.

of Lugard's The Dual Mandate in British Tropical Africa in 1922, the policy of the Condominium Government changed to one of Indirect Rule, known as Native Administration. Under this policy the 'tribal groups' gained autonomy and, with the guidance of the District Commissioner, settled their own problems at tribal meetings.

In 1956 the independent government of the Democratic Republic of Sudan succeeded the Condominium Government and in 1971 Native Administration was abolished and a system of Peoples' Councils took its place. This is the situation today. Officers are elected in villages and urban neighbourhoods to sit on their respective Councils, with representatives from each council sitting on the District and thence Province Councils. The hereditary titles of the sultanate have been officially abolished, though the individuals descended from these officials still tend to be recognized and given titles by the people. The titles of shaykh¹ and cumda² have been revised for the purpose of tax collection, a shaykh being responsible for a village or neighbourhood and an cumda for several shaykhs. Often these officials are from the original ruling families. The 1971 Peoples' Local Government Act ended the dual authority of local chiefs as administrators and judges. Justice is now administered by a separate council of judges, according to customary law, in the Peoples' Courts. In 1974 Darfur was divided into two provinces, north and south, each with its Executive Council and Commissioner; since 1980, the two provinces have been reunited under a Governor as the Region of Darfur.

1. shaykh - village chief

2. cumda - chief of several villages

2.5 NON-ISLAMIC TRADITIONS

As mentioned earlier, there are but few references to the area now known as Darfur or to that occupied by the Darfur Sultanate, until the beginning of the eighteenth century. Arkell does, however, mention an early writer, Yakūbi (c.1200 AD), who quotes another still earlier, al-Maḥallabi (903-963AD), in describing a Zaghawa kingdom. The description 'appears to refer to the whole area between Darfur (or perhaps Kordofan) and the eastern shores of Lake Chad', (Arkell, 1951:225).¹ The people of this area apparently worshipped their king, an absolute monarch. They were cultivators, mainly of sorghum, who also kept cattle, camels, horses and goats. It was the belief of these people that the kings brought life and death, sickness and health to their kingdom. Arkell is in no doubt as to the significance of this reference in the early account, for it lends weight to the evidence that the early rulers of Darfur were divine monarchs. Traditionally these early rulers are buried in some of the barrows near the summits of the Jebel Marra range, to which the Fūr, during Arkell's time still made the 'toilsome ascent in pilgrimage' (*ibid.*).

The accounts of Browne (1799), al-Tunisi (1854), Felkin (1885) and Nachtigal (1971) all contain evidence supporting the theory that the Sultan of Darfur was a divine king. As O'Fahey points out,

'Although some divine kingship customs were abolished as concessions to Islamic sentiment and although the later sultans adopted some of the attributes and style of the fugarā', the aba kuuri was not 'disestablished' as in Sinnār, and he kept a quasi-divine aura until the end.'

(O'Fahey & Spaulding 1974:141)

1. Here Arkell is quoting Yakūbi quoting al-Muḥallabi from the Geographisches Worterbuch, Leipzig, 1869, II:932.

All three of the early visitors to the Sultanate note the veiling of the lower half of the Sultan's face and Browne adds that a kind of umbrella was used to further conceal him from public view (Browne, 1799:214). All subjects approaching the Sultan took off their shoes and had to bare themselves to the waist and then moved towards him on their hands and knees. If the Sultan should pass by, all would kneel down. At the formal greeting of the Sultan, delivered through an intermediary, all present would rub the ground (Nachtigal, 1971:262). The Sultan apparently always ate alone and if he spat, his spittle was covered, if he sneezed or coughed, all around him made a clicking noise (Nachtigal, 1971:77). Until the time of Sultan Ahmed Bukr, according to Nachtigal (ibid.:326) when the Sultan died one of his dignitaries, the kamni (the Sultan's neck') was murdered. This person had much prestige but little actual power. When a Sultan died, fires maintained in the royal palace and the house of another dignitary, the ab-shaykh daali, were extinguished and were not lit anew until the next Sultan acceded (ibid.:328).

Certain ceremonies¹ bear witness to the fact that the Sultan was a divine monarch; the accession rituals and then the 'first sowing' and 'covering of the drums' were hedged about with much ritual. When a Sultan died, his death was kept a secret within the royal household for as long as possible, until the political manoeuvring over the next Sultan had been resolved; when this had been effected, the royal drums were

1. O'Fahey's account (1980:19-20) is the main source here, drawing on al-Tunisi's record of information from his informants - he arrived in el-Fasher just after the enthronement of Muhammed al-Fadl.

beaten slowly to announce the previous Sultan's death and then the beat was speeded up to announce the successor. The new Sultan then went into seclusion for seven days within the palace, until the ritual experts, old women, arrived to lead the Sultan to the house of the royal drums. As O'Fahey points out, this was probably the most significant part of the accession ceremonies, considering the importance of the drums, particularly the most sacred, al-mansura ('the victorious'). Al-Tunisi reports that the ritual experts chanted and clashed their throwing knives around the sacred drum within the drum house, but as only the Sultan and the old women entered the drum house, he could provide no further information. Following the drum house ritual, the Sultan was led to the throne (the only time in his life when he sat upon it) and was dressed in his cap, turban and shawl. The assembled chiefs then swore their oath of allegiance and it was announced that the Sultan had been enthroned. He then opened his diwan.¹

The other great national festival, the 'covering of the drums' was held, according to Nachtigal, as a kind of spring festival, marking the beginning of the year, 'notwithstanding the Muslim calendar' (Nachtigal, 1971:338). This festival lasted some 8-10 days and began with the offering of sacrifices and readings from the Qur'an at the tombs of the past Sultans at Turra in Jebel Marra. Sacrifices were then offered at the tombs of the pagan kings on Jebel Kora, without the readings from the Qur'an (ibid.). The day before the great drum festival, the Sultan, all members of the Kayra lineage and all other dignitaries attended the

1. diwan (Ar.) - office, hall, reception area.



'first sowing' ceremony. The Sultan put on a simple white garment and sandals (part of the royal heirlooms), cut down the remaining tree in a field which had been cleared for sowing and then sowed millet seeds in seven holes which he had just dug with a spade. These were then filled in by the ritual experts. During the return journey to the palace a hunt was held, precautions having been taken to ensure success. Having returned to the palace, at the time of the evening prayer two white cows and a white steer to be used in the next day's ceremonies were brought before the Sultan who chose one of the cows, the hide of which would be used to cover the drums. The following day the Sultan killed all three animals and then the hide of the chosen cow was cleaned and fitted to the drums by the chief blacksmith. A rib of the chosen cow then had to be smashed by the Sultan over the most sacred drum. In order to ensure his success in this act, due preparation was made apparently to forestall any ill omen. On the third day of the festival, the Sultan slaughtered a wether with particular markings, and its meat was distributed to certain individuals (the chief of the merchants getting the feet and lower legs, presumably in connection with the fact that merchants were always on the move in their daily work).

Three days after the great drum festival another ceremony was held, this was the 'feast of the entrails', in which loyalty to the Sultan was affirmed by the princes and princesses. The entrails of the wether killed three days previously (and by this time in a state of putrefaction) were mixed with butter taken from the drums, which had been placed there the previous year, by now rancid of course, and said to be a cure for eye complaints. (Before covering the drums, butter was again placed inside

for the next year's ceremony, the butter having already spent a year buried in the ground.) The meat and butter mixture was spiced with hot red pepper and then was ready to be eaten. Armed slaves stood behind each prince and princess, ready to kill if any one showed the slightest sign of nausea, vomiting or coughing, as it was believed that such signs indicated that an individual was contemplating treachery. Nachtigal records that a virgin may have been sacrificed up until the time of Sulayman Solong (Nachtigal, 1971:340).

After the feast, at irregular intervals, there were seven great military parades when the Sultan reviewed his chiefs and their retainers, all on horseback who could so manage. Nachtigal arrived in el-Fasher in time for the sixth parade of 1874 and he gives a detailed account (ibid.: 341-5). His description records that the Sultan wore silk clothes, that his face was veiled, and that he had on a suit of armour. The Sultan's horse was 'overloaded with ornaments'. There was much playing of musical instruments and chanting and many people marched in the procession. While the Sultan reviewed his horsemen, he was shaded by the royal umbrellas, of a red colour and embroidered with gold thread.

As Balfour-Paul (1955) records, there were many features in Darfur of non-Islamic (which he terms 'pre-Islamic') traditions surviving until recently. There are sacred hilltops where flour and water are sprinkled in sacred precincts, where people crawl on all fours and pray to the spirit of the place. He goes on, 'Almost everywhere you will find relics of tree-worship, of rock features taboo to the local king, of taboos on parents-in-law, of taboos on blacksmiths and donkeys.' He also points out that, 'Local wizards are universal', (Balfour-Paul,

1955:8). There is reference by Felkin (1885) to Molu (God) who lives in the sky and by whom men were created. Felkin observed that, at the time of his visit to Darfur, there were then some stone spirit houses on hilltops in Jebel Marra, dedicated to Molu and which were still being held in reverence at that time. In addition Felkin reports that the Fūr believed in a great spirit living on Jebel Marra with an immense army of spirit servants, capable of extraordinary powers. (Whether there is any connection between Molu and this great spirit is not clear.) Certain 'magicians' acted as mediators to the spirits and could enlist their help - for a suitable gift; others, it was believed, could transform themselves into animals, travel great distances in seconds, perform certain magical acts and had the power of divination and fortune-telling (Felkin, 1885:221-3). It is said that certain fegis living in the Kongyo mountain villages, near Zalingie (Western District, Southern Darfur), possess such powers and perform such acts to this day.

Although many stories record the features mentioned above and old people still recall them, it seems that they have now almost disappeared - at least in the area where fieldwork was carried out. Stories related by old people tell of sacred snakes and the trees or rocks where they live, tended usually by elderly women¹ who ensure the flow of offerings of beer and meat made to the creature. There are also tales of individual local rulers (who have retained their titles but without their former powers) who dare not pass a certain tree or rock without slaughtering a sheep, and of individuals who were reported to be able to cause rain to fall.

1. Perhaps the same ritual experts as those who would play a major part in the accession of a new sultan. Tubiana (1965) deals in more detail with such features among the Zaghawa in Northern Darfur.

These recently abandoned non-Islamic traditions, together with the rituals of divine kingship, provide an indication of the extent of the mystical aspect of Fūr traditions. As will be argued below, these traditions also provided a basis upon which the new faith could grow, embracing and moulding the original beliefs and practices until they conformed with the tenets of a rural, popular and uncomplicated interpretation of Islam.

2.6 CONVERSION TO ISLAM

All Darfurians are Muslims but until recently it would seem that at least some of the ancient non-Islamic traditions were still observed. It is of course possible that, in more remote areas of Darfur which were not visited during fieldwork, there are still some of these traditions kept alive but none were witnessed or recounted by informants. However, while travelling from el-Fasher to Rokirroh, in Jebel Marra, a large tree was pointed out, where, it is said, the funeral processions of the Sultans halted on their way to Turra. There are many trees and rocks of significance in Darfur passed which certain individuals would (or will) not go, unless they make some offering, for fear of their lives. An elderly informant told of how he was walking with a Jebel shartai who would not cross a certain road because he did not have an animal to slaughter. The same informant told of another shartai who (on hearing a sound coming from the mountain) said, 'This will be my last year' and died two or three months later. This informant believed that during the

last 50 years many such beliefs have died out. The writings of Beaton (1948) and Arkell (1951) would bear this out and, having been written some 30 years ago, contain eye-witness accounts. One belief in particular encountered from many informants is that certain people, in particular the feqis of Jebel Kongyo, can transform themselves into animals.

There is no possibility of dating the conversion to Islam of the people of Darfur; it seems to have been a long, slow process. Following the Islamization of Egypt and the Maghrib, traders with their caravans of camels travelling south across the Sahara, propagated the Muslim faith along the trade routes. The Fūr legendary story records the arrival of Ahmad al-Ma'qūr (who is believed to have been an Arab from the Maghrib) in the time of the Tunjur, i.e. before the seventeenth century. O'Fahey believes that feqis from the west also arrived in Darfur in the time of the Tunjur, (O'Fahey, 1980:117). With the Islamization of Darfur, following that of Wadai and Sinnar, there opened up a potentially fairly safe route across the savannas for pilgrims from the West travelling to Mecca, although, according to Birks (1978: 12-14), this may not have been so safe in practice. At this time, Islam was a court religion only, but during the eighteenth century Sultan Abd al-Rahman al-Rashid actively encouraged religious teachers to come to Darfur from the east. These teachers brought with them the Arabic language and the Muslim-Arab way of life, which are both now found, to varying degrees in Darfur.

At first the knowledge of Islam can only have been superficial but then the rulers and aristocracy were converted, no doubt being aware of the numerous ways in which the feqis could assist them in asserting their

pre-eminence, through jurisprudence and literacy. Some sultans were religiously oriented, such as Sultan Abd al-Rahman al-Rashid, and encouraged the conversion of their subjects through the feqis. However, it appears that until fairly recently, some non-Islamic traditions were still being practised by the Fūr.

A characteristic of Islam noted by Trimingham (1965:163) is its inherent tendency to assimilate and integrate customs, beliefs and practices of the society where conversion occurs. According to Lewis, this is due to a dynamic process of adjustment and adaptation, (Lewis 1966:67). Islam embraces where possible and where this is not possible, offers alternatives. For example, elements such as spirits, witchcraft and sorcery can be embraced - though not necessarily approved - due to their recognition in the Qur'an - but ancestor worship, found in African religions, is not acceptable and the emphasis in West African Islam is on spirit possession cults. The emphasis further east in Sudan and in the Maghrib and Egypt, is upon the cult of saints, shrine visiting and spirit possession cults such as the zar.

As mentioned above, Darfur was influenced by Islam from three directions, north, west and east. Thus, one might expect to see evidence of the cultural features of Islam found in those three regions. However, this is not so. Spirit possession seems to be almost completely lacking in Darfur, except where a few very individualistic women have introduced their own versions, in which they themselves become possessed in their search to divine the sickness of others. Only one woman encountered, claimed to have any followers who also became possessed, and these had

not met for more than a year at interview. Saint cults do not take the form of those in other parts of Northern Sudan; there seems to be little or no shrine or grave visiting (there are no domed tombs - qubbas) and the Tijaniyya ṭariqa¹ is of fairly recent advent.

The Tijaniyya ṭariqa is the one most widespread in Darfur and is characterized by its simple ritual and philosophical, rather than ecstatic mysticism, (Trimingham 1965:236-239). The personal qualities of the leader, mainly his holy power (Ar. baraka), would seem to be the binding force in this order rather than the embracingly hypnotic effect of incessant repetition of the names of God, or other formulae, (accompanied by rhythmic drumming and movements in the dhikr² as practised by many other brotherhoods in their search for spiritual mysteries). The majority of feqis in Darfur are members of this ṭariqa.

The Tijaniyya ṭariqa was founded in 1781 and was introduced into Sudan in the mid-nineteenth century by al-Mukhtar Abd al-Rahman al-Shanqiti, a rich merchant who travelled throughout Sudan and Egypt and acted as an ambassador between the Sultan of Darfur and the government of Egypt. Al-Mukhtar introduced Sultan Muhammed Husayn into the ṭariqa (*ibid.*). There are nowadays three important Tijaniyya shaykhs in Darfur - in el-Fasher, el-Geneina and Musa Bikra (to the south of Nyala). In the Tijaniyya mosques, the dhikr is performed once a week, on Fridays. The followers of the ṭariqa sit in a circle in the mosque and chant the dhikr in low, controlled voices, supervised by the leader or imam.

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1. ṭariqa (Ar.) - way, path, of the leader/shaykh/saint of Sufi brotherhood.
 2. dhikr - an incessant chanting, of the names of God, sometimes accompanied with drums and dancing in dervish orders, in order to attain gnosis.

In general, Islam as practised by the Fūr is a simple straightforward version of the faith, apparently unaffected by the various unorthodox practises which are found in the regions from which the religious teachers originated. This may be due partly to the lack of fervent missionizing in the region. The holy war (jihad) movements of the late eighteenth and nineteenth centuries had little effect on the Fūr, who tended to be anti-Mahdist anyway (O'Fahey and Spaulding 1974:186). Despite the centuries of missionary work on the part of the feqis brought by the sultans, and the traders and pilgrims who passed through Darfur, conversion was very gradual. Fūr religious traditions have slowly died away; at no time were there any purges which might have channelled religious zeal one way or the other. This gradual conversion was concluded coincidentally with the colonial occupation of Sudan.

2.7 THE INFLUENCE OF ISLAM ON SOCIAL LIFE

Apart from the effect on the religious belief and practice of the Fūr, Islam as a way of life has played a part in the sphere of the private, social existence. In Sudan the public sphere of life is regularized by secular laws; marriage, divorce and the custody and care of children, and inheritance are all conducted according to Islamic shari^Ca¹ law. The seclusion of widows for four months and ten days and divorced women for three months or three monthly cycles after the death of the husband or the divorce, is prescribed in the Qur'an (Sūra² II, vv.234 and 228, respectively). Guidance for choosing the name of a child is to be found

1. shari^Ca (Ar.)-revealed or canonical law of Islam.

2. sūra (Ar.)-Chapter of Qur'an.

in the Ḥadīth.¹ The naming of a child should ideally be on the seventh day following the birth, if this is not possible, it is held on the fourteenth day. Prescription regarding burial of the dead is also to be found in the Ḥadīth.

The customs of seclusion of women following childbirth for 40 days and the, apparently increasingly popular, custom of female circumcision with infibulation (pharaonic) are both non-Islamic practises.² New mothers are, however, excused from praying for up to 40 days following a birth, in the Ḥadīth. The Islamic practice of male circumcision is of great importance in Darfur; it is an occasion for much ceremonial, not only for the boys themselves but also for their families and for the whole community.

The Islamic marriage takes place by the signing of the contract between the bridegroom's representative and the representative or guardian of the bride, following the offer and acceptance of marriage made in front of witnesses and perhaps a feqi or imam of a mosque. Divorce takes place when a husband declares before witnesses that he divorces his wife. If there is a problem with alimony, custody of children etc. then the case is taken to be judged by the judge in the shari^ca court. Among the Fūr, marriage and divorce generally follow the pattern described above. However, although sultans, feqis and wealthy men apparently used to have many wives concurrently in the past, this practice was not encountered during fieldwork.

1. Ḥadīth (Ar.) narrative relating deeds and utterances of The Prophet.

2. see Chapter 4, pp.165-166.

The law regarding shari^Ca inheritance is sometimes pre-empted by an individual giving some of his/her immovable property, such as a particular fruit tree or trees to a chosen individual. There is also a notion of 'family land' in Darfur, which was given by a sultan long ago, remaining as the land of that family. Nowadays all land belongs to the state and permission is required in theory from the local shaykh or Cumda to cultivate such land. (Incidentally, it is likely that the shaykh or Cumda would be the descendant of the family originally given the land.)

Preparation for the burial of the dead follows the Islamic tradition. In the mountain villages, the Fūr tend to construct the type of grave where the first chamber is dug in the usual manner, while the second one is dug into the east wall, as opposed to the floor, of the first chamber.¹

The wailing and lamentations of urban women after a death and during the period of the funeral is disapproved in the Ḥadīth (Bukhari, 1976(2): 221) and is generally not practised among the rural Fūr.

A characteristic of Islam in Darfur is the custom for the majority of boys to become muhajarīn (emigrants) and wander from teacher to teacher all over Darfur, while learning to recite the Qur'an. Many continue in this fashion into their early twenties and some for longer, especially if they find one teacher to whom they can become apprenticed in order to learn the healing art of the feqi.²

This summary can only indicate where Fūr social life has been influenced by Islam. The way of life in Darfur, however, precludes women from a secluded life, even for short periods of time. The struggle

1. See chapter 4 (4.3.5).

2. See chapter 7.

to grow enough millet (and other cash crops if possible) by traditional Fūr farming techniques where both men and women farm their own plots of land, pooling labour when necessary, means that men and women are often working together. The type of work also prevents women from wearing figure-concealing wrappings, such as the diaphanous tōbs worn by urban women.

2.8 THE INFLUENCE OF ISLAM ON THE MEDICAL SYSTEM¹

Until the beginning of the 20th century there was very little contact between Darfur and the western world, but the sultanate was situated at the cross-roads of two of the major routes across Africa - the pilgrimage route from the west and the 'Forty-Days Road' (the darb el-arb^Caiñ) the slave-trade route to Cairo. These two roads would have brought many Muslims, and many Arabs, to Darfur in addition to those invited by the sultans to teach the Darfurians Islam. These people would have brought with them ideas and beliefs as well as practices, from their own part of the Islamic world, which in conversation, teaching and in practice would have been passed on to their students, friends and acquaintances. As far as medicine is concerned, this transmitted knowledge would have consisted of various aspects of Islamic medicine - classical Arabic medicine, health instructions in the Qur'an and Prophetic and sufistic medicine. Each of these will now be examined

1. The main sources consulted for this section are: 'tibb' in Encyclopaedia of Islam (1934 ed.); Encyclopaedia Britannica, 1981; Poynter and Keele (1981), A short history of Medicine; Ullmann (1978), Islamic Medicine; Browne (1962), Arabian Medicine.

briefly in attempting to determine the nature of the influence of Islam on the medical system in Darfur.

Since the mid-seventeenth century, when Sultan Sulayman Solong was converted to Islam there has been a tradition of movement towards Darfur by religious teachers as well as through it by pilgrims on their way to and from Mecca. The majority of the religious teachers were ṣufis, following the Tijanniya ṭariqa, whose philosophy includes much on the subject of sickness and healing, as well as preventive measures.

The works of the great Arab physicians, who were clinicians and philosophers rather than discoverers in the field of medicine, were known to Muslim scholars. They also translated the works of the Greeks, Persians and Syrians into Arabic following the conquest of Alexandria in 642 AD. From the second century, the works of Galen had such an impact on Arab physicians that they adopted the Galenic system in its entirety. This meant that the people who had so recently adopted Islam as a way of life, were confronted with a system of ideas and practices which had developed in what they considered to be a heathen culture. The result was that some orthodox Muslims, according to Bürgel, were suspicious enough about the propriety of utilizing such a system that they created one in competition; this came to be known as the Medicine of the Prophet (el-ṭibb el-nabi), (Bürgel 1976:46). By the time of the introduction of Islam into Darfur, the variety of knowledge which could be subsumed under the term 'medicine' was vast and varied, ranging from the translated works of Galen to the collected traditions of the Prophet (Ḥadīth) and the beliefs and practises of ṣufi shaykhs based upon their mystical, philosophies, and a few health instructions

found in the Qur'an. For the purpose of this study, these three divergent medical philosophies, together with the Quranic instructions, are regarded as being the components of Islamic medicine.

Islamic medicine developed in the lands where Islam became a way of life and has continued to form part of the medical system of many peoples, to a greater or lesser degree and with emphasis usually on one component more than the others. Many books have been written over the centuries which contain sections on all four components of Islamic medicine but very often there is no clear distinction and the various ideas are intertwined.¹

The great tradition of classical Arabic medicine goes back to the eighth century when translations were being made from the Greek works. These had already developed through four major theoretical stages concerning disease aetiology. Following on from earlier supernaturally based theories, medical thought began to move towards a concept of disease due to natural causes. The early theories conceived disease as being due to imbalance of the four 'elements' earth, air, fire and water in association with four 'humours', black bile, yellow bile, blood and phlegm and certain 'qualities', such as wet and dry, hot and cold. Other theorists brought in certain physiological features such as blood being sucked into the arteries from the veins (where, they believed, only air and spirit should have been present) and tension in the pores

1. During fieldwork several old books were found to be in the possession of healers in Darfur. These contained material from all aspects of Islamic medicine. Books with titles such as Manba' usul al-hikma ('The source of the origin of wisdom') and Khazinat al-asrar (The treasury of secrets) can be found at the pavement stalls in Khartoum.

of the skin, as the basic aetiological factors. After all these theories had been denied by those who believed that treatment should not depend on diagnosis, but trial and error, Galen began his anatomical research. On the basis of his research he built up a theory of physiology which lasted until Harvey discovered the circulation of the blood, in 1628.

Humeral pathology was the essential feature of the Galenic theory of aetiology; it was believed that food, after being taken into the stomach, was 'boiled' and thus changed into other substances, some of which were useful, others of which were not and were excreted. The useful substances were 'boiled' again in the liver and then transported by the blood to the organs and limbs. The products of the 'boiling' process were black and yellow bile, blood and phlegm and these combined with the four qualities, hot, cold, wet, dry, to produce a state of mutual equilibrium when the individual was healthy. The Hippocratic school had maintained that it was essential for the humours and their qualities to be in a balanced state (eukrasia) for health and that if they were unbalanced (i.e. in dyskrasia), then sickness was the result. Galen, however, maintained that there was no such thing as an ideal state of the humours and qualities, but that every individual had his own formula, with one humour being dominant and so prevailing in his temperament. Galenic therapy rested upon the principle of opposites, 'cold' diseases receiving 'hot' therapies, and 'wet' diseases receiving 'dry' therapies. Combined with these allopathic therapies, the physician should teach his patients how to restore and then maintain the symmetry of his temperament, having first logically reached a conclusion

concerning the particular case by derivation from the generalizations of the textbooks.

Hospitals were an important feature of the majority of Muslim Arab towns; usually they were built and provided for by benefactors. It would seem that the patients were treated in a particularly kindly way and that care was taken to feed them well and to enable them to relax and sleep well; for this purpose musicians and story-tellers were employed in the hospitals. The mentally ill were also well looked after.

The possible influence of Arabic medicine upon that existing in Darfur today has not been studied, as far as I am aware, but it would seem highly likely that simplified and popularized legacies from the 'great tradition' would appear in the natural aspect of Fūr country medicine. Reference was often made by informants to changes in temperature and general changes in the environment as sickness cause. The rural Fūr often mentioned bile (F. dwillla) as the cause of some symptoms, though they did not define any colours of bile. Certainly the Fūr have a vast pharmacopoeic store amongst them and many individuals are well-versed in a great number of drug therapies.

In her thesis on Islamic Religion as a basis for a Health Education Programme (1979), Aida Abd el-Azim el-Banna has noted the advice given on avoidance of alcohol (Sūra V:93) and implicit suggestions for good community and environmental health (Sūra VII:56) and also for general healing (Sūra XIII:28).

The Qur'an itself mentions neither doctors nor medicine but there are a number of references which outline instructions pertaining to health. These are then further elaborated in the Hadith.

Muslims are advised upon everyday hygiene and the necessity of ritual purity in Sūra V:7 of the Qur'an and explicitly forbidden to carrion, blood and swineflesh in Sūras II:173 and V:4, although there is no reference to the medical reasons for either instruction. The only plain reference to health is contained in the following from the Sūra known as 'The Bee'.

'Then eat of all
The produce (of the earth),
And find with skill the spacious
Paths of its Lord: there issues
From within their bodies
A drink of varying colours,
Wherein is healing for men:
Verily in this is a Sign
For those who give thought.'

Sūra XVI:69

In the Qur'an mention is made of menstruation, and advice given that husbands should give their wives consideration at this time (Sūra II:222). There are also many references in the Qur'an concerning the creation of Man and procreation.

In the pre-Islamic era, life in the deserts of the Arabian peninsula, as nowadays, would not have been easy. The scarcity of water, with its concomitant health hazards, must have laid all but the hardest bedw¹ open to the infections, infestations and endemic diseases which are prevalent in such conditions. This predisposition to disease is aggravated particularly by the presence of flies and a diet lacking in fruit and vegetables and thus also many vitamins and other trace elements. The majority of the Arab peoples were dependent upon their own traditional

1. bedw - desert nomads.

'folk' remedies, originating in mystical thought and belief, symbolic ritual and empirical practice.

Old Arabic poetry¹ gives some idea of the knowledge of the Arabs in the field of medicine. The organs are described together with their supposed functions, as well as the common forms of treatment favoured by the Arabs, particularly cauterization and cupping. Many healers in ancient Arabia were, apparently, women. They used physical and dietary remedies but were also sooth-sayers who 'took refuge in magic incantations', (Ullmann, 1978:4). Many of the dietary remedies then and now make use of local animal products, particularly camel's milk and urine, animal fat and honey, while others utilize a variety of plant materials. Such was the position of medicine in the lifetime of the Prophet Muhammed, in Arabia.

The Ḥadīth (Traditions of the Prophet), of which there are several respected versions, is regarded as the most authoritative work on the life and times of the Prophet. In the Ḥadīth are included chapters on medicine and instructions for health care but there is little evidence of influence from Greek medicine, which was being translated into Arabic at the time of compilation of the Ḥadīth. Because of its connection with the Prophet, the medical and health instructions in the Ḥadīth were studied, interpreted and moulded into a distinct body of knowledge, quite independent of that which was to develop as Arabic medicine. This body of knowledge became known as the Medicine of the Prophet (el-Ṭibb el-Nabbi)²

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1. Ibn Qutayba (d. 276 AD) made two collections of pre-Islamic poetry in which mention is made of certain ailments and their treatments, viz. Uyūn al-Akhbār, (Cairo 1963, vol.III:208) and al-Maḥāṣin al-Kabīr, (Hyderabad-Deccan 1949:366).
 2. Perhaps the best known is that of al-Suyūṭī compiled in the 16th century and translated by Elgood, 'Ṭibb ul-Nabbi or Medicine of the Prophet', Osiris, 1962.

and, as Ibn Khaldun points out:

'The medicine mentioned in religious tradition is of the (Bedouin) type. It is in no way part of the divine revelation. (Such medical matters) were merely (part of) Arab custom and happened to be mentioned in connection with the circumstances of the Prophet, like other things that were customary in his generation.'

(trans. by Rosenthal, 1967:150)

The material of the Ḥadīth according to Bürgel (1976:55-8) falls into various categories concerning theological problems, mainly regarding what the Prophet had said at the times when he was faced with sick people; ethical and social issues concerning the visitation of the sick, correct behaviour at the bedside and the nursing of unrelated men by women; popular health rules mostly derived from bedw folklore concerning diet; drugs and other remedies, being mainly honey and black cumin and the use of surgical therapies such as cutting, cupping and cautery (the last of which the Prophet did not approve); magical healing and apotropaeic measures such as reciting the last two sūras of the Qur'an, which were implicitly permitted while black magic such as the wearing of amulets against various evil powers, and sorcery were strictly forbidden, (Sūra II:102-3).

There is little recorded of what the Prophet actually said about the treatment of sickness, apart from the following ḥadīths: 'There is no disease Allah created but that he created its treatment' (al-Bukhari, 1977,7:395); that 'Healing is in three things, a gulp of honey, cupping and cauterization, but I forbid my followers to use cauterization' (op.cit. 396); that fever is from 'the heat of hell so abort it with water', (op.cit. 417). It is said that the Prophet experienced all these

treatments himself but was not at all in favour of the highly esteemed Arab treatment by cauterization. It is believed that he practised faith-healing combined with the power of touch, (op.cit. 382).

Other references in the Ḥadīth are related to the question of health, prevention of sickness - particularly, the Prophet advises against visiting any place where there is disease of an epidemic nature - visitation of the sick and how best to encourage and console them, protective prayers and measures to be taken against the evil eye.

Those writers who have gathered together the sayings and actions of the Prophet which are relevant to medicine, have presented them, together with their own elaborations, against the background from which they originated, the customs of the nomadic desert people, (Elgood, 1962:37). From the 9th century, the treatises entitled 'El-Ṭibb al-Nabī' began to mix Galenic with Prophetic medicine, a procedure which served only to add religious mysticism and magic to the Galenic medical science, rather than increasing critical thought on the matter, (Bürge, 1976:58). Examples of such works are the two mentioned earlier in this section (p.64) - Manba^c usūl al-ḥikma and Khazinat al-asrār.

The aspect of Islamic medicine which is particularly related to sufism is considered separately from the main body of Prophetic medical tradition because its development has been in the somewhat unorthodox practices of 'popular Islam'. However, the origin of sufistic medicine seems to have been in the few recorded instances of the use by the Prophet and his followers of recitations of certain verses of the Qur'an against the evil eye, especially the last two sūras:

1. Say: I seek refuge
With the Lord of the Dawn,
2. From the mischief
Of created things;
3. From the mischief
Of Darkness as it overspreads;
4. From the mischief
Of those who practise
Secret Arts:
5. And from the mischief
Of the envious one
As he practises envy.

Sūra CXIII. The Dawn

1. Say: I seek refuge
With the Lord
And Cherisher of Mankind,
2. The King (or Ruler)
Of Mankind,
3. The God (or Judge)
Of Mankind, -
4. From the mischief
Of the Whisperer
(Of Evil), who withdraws
(After his whisper), -
5. (The same) who whispers
Into the hearts of Mankind, -
6. Among Jinns
And among Men.

Sūra CXIV. Mankind

This method of traditional healing is now a common and universal practice throughout the Islamic world, and is particularly prominent in Darfur; it has been amplified and supplemented over the ages by the

leaders and followers of ṣufi ṭariqas, and the various religious verses and other recitations have been given a further dimension, as written words. Healing practices utilizing the art of script began to include secret magical codes and formulae whereby words and texts, letters and numbers could be manipulated and visibly stored, on paper, thence to be concealed from public view by the owner. The tradition of an intrinsic mystical power associated with certain arrangements of letters, numbers, words, texts and particularly with the names of God, goes back to the beginnings of writing itself in the lands of the fertile crescent, perhaps with additional eastern influence in the case of numerical manipulation, (Goody, 1968:17).

While Prophetic medicine is such that ordinary people can practise it themselves - as a home therapy or self-help method of treatment - certain procedures, which derive from the concept of mystical disease cause, come into the sphere of the practitioner of spiritual healing, the feqi. As will be described in greater detail in Chapter 7, the feqi (or shaykh of a ṣufi ṭariqa) first of all is an individual who has the respect of others. This is due to his knowledge of the Qur'an and the assumption of his 'other worldliness'. He is, perhaps unwittingly, a student of human nature and character and resourceful in his attempts to relieve the suffering of others. His preventive and therapeutic techniques can be recognized by his clients as having their basis in Islamic doctrine but at a level which is understood by the majority, many of whom would be illiterate, or at least not in a position to use their limited Quranic literacy for further advancement of knowledge.

Techniques used by feqis are those of performing cazīma¹ (which is believed by most people to be the most correct way of using holy words in healing), making mihaya,² praying using the rosary (sibha), writing amulets and bukharat.³

2.9 NON-ISLAMIC MEDICINE

From time immemorial, man has endeavoured to find relief from his ailments. In doing so, he has developed practices of treatment and theories of disease cause which have their roots in religion and mystical thought - those concepts by which man seeks to understand and gain knowledge of what is just beyond his grasp. Some individuals have, of course, always been more interested than others in this field and by their observation, intuition and reasoning have developed skills not realized by the majority. In this way, a fund of knowledge concerning the diagnosis of sickness, materia medica, therapy, anatomy and to a certain extent, physiology, could develop and become the carefully guarded property of its possessors. Such a traditional or folk medicine might be found in any society prior to influence from the major schools of philosophical and scientific thought.

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1. cazīma (Ar.) - literally incantation or spell, but here it refers to holy words blown towards and over an individual.
 2. mihaya (Ar.) - erasure of holy words washed off a wooden board into a vessel - the liquid is then drunk.
 3. bukharat (Ar.) - small papers, each with holy words written for burning - the smoke to be inhaled and to fumigate the person. bukhara (sing.) = steam, fumes, vapour. (See Chapter 7 for more details.)

As mentioned earlier (pp.53-55) there are some surviving archaeological remains in the form of sacred precincts on hilltops, certain trees and rocks as well as recorded or remembered customs in Darfur. These lead one to believe that, before the Fūr became Muslims, their religious and daily activities were governed, at least in part, by the divine personage of the sultan and his supposed effect on the fertility of the soil and general state of health of the community. The additional belief in the creator God (Molu) and/or the spirit believed to live on Jebel Marra with his army of obliging spirit servants, supports the hypothesis that (in the Darfur Sultanate), the aspect of life concerned with the sacred had a broad base and allowed for such diverse features as a single creating deity, an earthly god-king and a pantheon of spirits together with their human intermediaries. The fact that these elements existed in Darfur before the introduction of Islam and that it was believed that the spirit intermediaries could perform magical acts, carry out divinatory techniques, tell fortunes and transform themselves into animals is notable. Today there are to be found in Darfur, many feqis and some female spirit mediums who operate in a similar sphere. There are still, in parts of Jebel Marra, a few individuals who maintain that they have powers over spirits or can mediate with them; they are known locally as jiddonga¹ or as jinny² in other parts of Darfur (see Chapter 7). The jiddonga performs a

1. jiddonga (F) - a spirit or spirits contactable through a diviner, particularly with regard to physical and mental welfare. The concept of the jiddonga incorporates the diviner, but may also mean the spirit(s) alone.

2. jinny (Ar. coll.) - a spirit (from jinn.)

divinatory or diagnostic function and recommends where therapy should be sought.

The topography and climate of Jebel Marra and the Western District of Darfur is such that it supports a wide range of vegetation which has proved favourable to the continuous presence of agriculturalists, for centuries. Even considering recent decreases in rainfall, the area is relatively green and fertile when compared with the surrounding desert. The majority of plant materials used today by practitioners of country medicine are found growing in the mountain or along the banks of the seasonal rivers and streams. There is no reason to think that the plant materials or the medicinal uses to which they are put, should have changed drastically over the centuries.

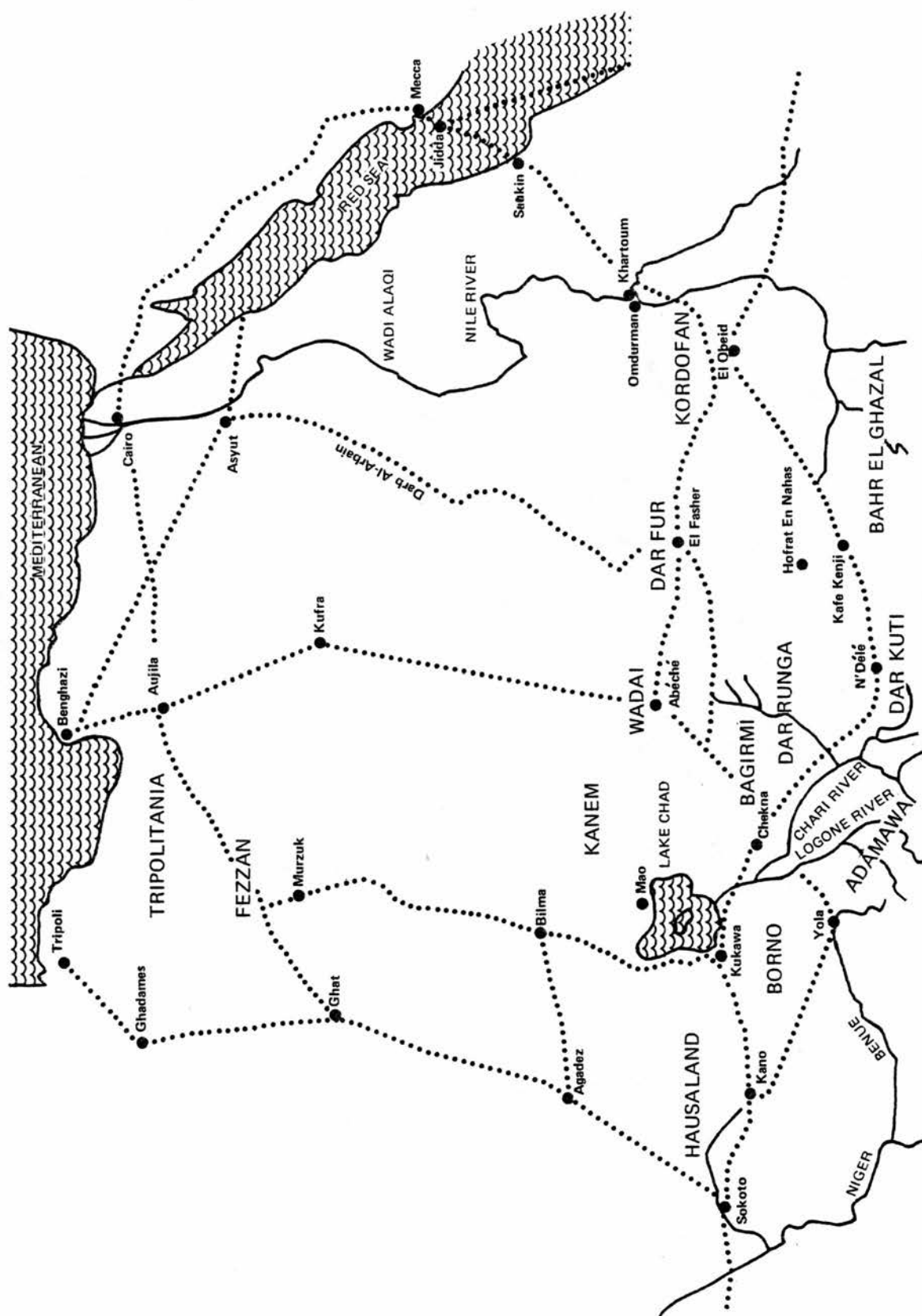
Other techniques of healing which do not have a base in Islam are the surgical practices often carried out by blacksmiths, such as bone-setting and joint manipulations, while others such as eye operations are performed by the Fellata (Muslim West African) who have settled in Darfur while en route either to or from Mecca.

2.10 THE INFLUENCE OF PILGRIMAGE, LABOUR MIGRATION, TRADE AND EDUCATION ON LIFE IN DARFUR WITH REGARD TO MEDICINE AND HEALTH

Pilgrimage and trade have brought people to Darfur, some of whom have stayed for a short period of time while others have settled for generations. Labour migration has meant that a majority of young men born in remote villages are absent for some few years after completing their time as muhajarīn. Formal education has also played a part in

the absence of those who are attending school, college and university. However, it is certain side effects of the population movements which are of interest here, rather than the actual increase or decrease in numbers caused by exits and entries to the region. The movement of peoples from one area to another is likely to bring about an increased general knowledge about life outside Darfur and, more specifically, about medical and health facilities available in other parts of the country. It also increases the likelihood of epidemics.

During the 17th century there was a drift towards Darfur by teachers of Islam from other parts of Sudan, due to the encouragement of various sultans. However, once Darfur became a Muslim sultanate, the Darfurians themselves wished to perform the pilgrimage and as the majority were poor they had to take the least expensive route possible. This route passed directly eastwards through the eastern savannas; those taking it risked attack and robbery by non-Muslim peoples, even after the annexation of Kordofan by Sultan Tayrab in the mid-eighteenth century. Before this time, the more wealthy and the nobility had travelled north along the darb al-arb^Cāin (the Forty Days Road to Cairo) and joined one of the caravans on the North African route to the Hejaz via Sinai, (Birks, 1978:12-14), shown on Map 1.



..... main pilgrimage and trade routes

MAP 1 Main pilgrimage and trade routes in relation to Darfur.

Today the position of Darfur is ambiguous, for having been a historical focal point in Africa, it has become remote in the technological age due to communication difficulties. It is some 800 miles from the nearest international airport at Khartoum, although there are three small airports for internal flights in Darfur, (at el-Geneina, el-Fasher and Nyala) and a few cleared strips enabling small planes to land and take off in the dry season.¹ One such small landing strip is situated approximately 3km. (2 miles) outside Zalingie. However, most pilgrims could never afford to take advantage of air transport and the main method of transportation to and from Darfur is by lorry, and the railway from Nyala. Those who cannot afford this, walk or use donkeys. Lorries travel between the three major towns, the smaller market towns and to many large villages in connection with the carriage of produce and goods for sale. Even when full of goods, these lorries carry a great number of people together with their belongings. Nyala and el-Fasher are connected by a daily bus service in addition to the lorries which make the same journey. Lorries also run to Khartoum and to the main towns of Kordofan, el-Obeid and el-Nahud. The nearest sea-port today is Port Sudan, previously it was at Suakin, and it is the main point of embarkation for the ferry across the Red Sea to Jeddah. Port Sudan is some 1600km. (1000 miles) from Darfur.

The pilgrimage to the Holy Cities of Islam in the Hejaz, is something which all Muslims endeavour to carry out at least once in their lives. The pilgrims from West Africa have been travelling along the savanna

1. Used occasionally for visiting officials only.

routes to Sudan for about two centuries now and have been joined by those of Darfur in the trek east and then back. Many have remained in Darfur to collect more money for the onward journey, sometimes by farming in the rural areas, or by working as urban labourers, laundrymen, barbers and tanners. Some have settled in small hamlets close to towns. All the people of West Africa are generally called Fellata by the Sudanese; they tend to keep themselves separate from the Sudanese population of the towns and villages where they live in Darfur, even though some families have been settled there for several generations. Many fegis as well as other healers, are from these Fellata families.

As indicated already, many Darfurians take the route eastwards and are away for some years working in the Gezira and in Khartoum, in the hope that they will make enough money for their onward journey. However, it is not only the pilgrimage which takes men away from Darfur.¹ Two other factors must also be considered - labour migration and education. Since the Gezira Scheme began, more than 50 years ago, many Darfurians have travelled to the area specifically to work on the scheme, to save enough money to get married and perhaps to start a small trading business. The majority of boys and young men, in their travels as muhajarīn,² cover much of Darfur and some go further afield; a few reach the Islamic university of al-Azhar in Egypt where they attend lectures and listen to the great teachers of Islam.³ Those students

1. For further information on Migration from Western Sudan, see Taj el-Anbia Ali el-Dawi, 1975.

2. See Appendix 2 for details concerning life of muhajarīn.

3. Those who are not formal students of al-Azhar University are able to attend some lectures and open discussions.

who continue their formal education to senior secondary school, college or university also travel far from their homes. From the main towns of Darfur they go on to Khartoum or perhaps Wad Medani, making a visit home in the vacations.

Since the religious teachers were encouraged by the Darfur sultans to travel west, traders from the Nile area have followed their example. In all the main towns of Darfur, province and district centres, the majority of established and flourishing merchants and traders are from the Nile area, either Ja^Caliyyīn or Danagla, commonly known as jellaba. There are also scattered throughout Darfur, Hausa traders who have usually completed their pilgrimage and then set up in business along the savanna caravan routes, settling in one of the Hausa hamlets near a village or town.¹

Apparently there is no decrease in the numbers of pilgrims travelling overland and taking the savanna route to the Red Sea, despite the increased use of air travel by the more wealthy West African pilgrims. Even charter air travel is far beyond the reach of the majority of pilgrims (Birks, 1978:133). Thus, the slow movement of people across the savannas and back goes on and with it the risk of the spread of disease of epidemic proportions. Despite the efforts at the four border quarantine stations, the majority of pilgrims entering Sudan do so illegally and therefore without international health certificates of vaccination and inoculation, crossing the 2200km. (1500 miles) of open boundary, between Darfur and Chad, Libya and the Central African

1. The mixed motives for pilgrimage/migration are dealt with in Birks, 1978:18-20.

Republic, where they wish. This illegal crossing poses a major threat to any eradication programme, (Prothero, 1965:51).

Bayoumi (1972) in a paper on the socio-medical aspects of the pilgrimage points out that the Muslim population of the world generally resides in a belt which encompasses several countries where the classical infectious tropical diseases are endemic, such as cholera, typhus, yellow fever and (at the time of his paper, 1972) smallpox. These diseases, with cerebro-spinal meningitis and relapsing fever have, in the past caused thousands of deaths which can be directly traced to contact in the Hejaz or due to the passage of pilgrims either to or from Mecca.

Relapsing fever and cerebro-spinal meningitis have been known in Darfur particularly in the late 1920's, the 1930's and 1940's. Riding and Macdowell (1927) and Kirk (1939) proved that the relapsing fever was of the louse-borne type. Riding and Macdowell believed that, having spread from further west, it reached Darfur in 1926 and formed an endemic focus in Jebel Marra, spreading as an epidemic in the Zalingie district and along the Wadi Azum, and north to Kabkabiya and south to Nyala, (Riding and Macdowell, 1927:525-6). According to the Annual report of the Sudan Medical Service of 1927, cited by Bayoumi (1972:110), 10,000 deaths were estimated in Zalingie district alone, which had a population of 45,000. Darfur and Kordofan were severely affected again by relapsing fever in 1944 and 1945, but since then the disease has been of insignificant proportions, (ibid.).¹ Cerebro-spinal meningitis is a

1. These outbreaks of relapsing fever, and also cerebro-spinal meningitis, are noted by Boustead in his Hand-over notes to the new District Commissioner (1949).

disease essentially of rural areas, although it does occasionally break out in urban areas. Mortality was high until the introduction of the sulphonamide drugs in the 1940's. According to Waddy (1962:102) cycles of meningitis have always started in the Sudan and spread westwards from the Mongalla area to the south of the Sudd, where it is an endemo-epidemic disease but Erwa, Satti and Abbas (1971:106) suggest now that it is not cyclical and that it is becoming an accepted feature almost every summer. Lapeyssonnie (1963) has described a Meningitis Belt, stretching across Africa between the 300mm. and 1100mm. isohyets, which incidently, is overlapped by the pilgrimage route. In 1936 and the early 1940's Darfur suffered particularly violent epidemics.¹ Prior to this, Zaki (1953) (quoted by Erwa, Satti and Abbas, 1971:101) records that old men recalled epidemics in the time of Ali Dinar (in 1912) and his predecessors (in the late 1880's).

Smallpox has only recently (in December 1979) been declared eradicated from Darfur, Sudan and the world. Sudan was one of the last African countries to be declared free of smallpox by the World Health Organization. The recorded outbreaks of smallpox in Darfur have been in 1927, 1949 and 1951-2, (Annual Reports of the Sudan Medical Service, cited by Bayoumi, 1972:111) and there was a small outbreak in Zalingie in 1965, (Watson and Lundquist, 1967). All these outbreaks were traced to West African pilgrims or visitors from Chad, most of them had evaded the quarantine station at the Chad border. Another epidemic of smallpox spread to all parts of the country during 1968.

1. See footnote p.81.

Whilst perhaps the majority of epidemic disease has been brought to Sudan from West Africa, cholera has come from the Hejaz and there were many epidemics there up until 1913. A quarantine station, opened in Jeddah in 1956, has eased the situation regarding pilgrims to a great degree, (Pollitzer, 1959:974).

Although malaria is not a 'communicable disease' as such, its transmission and attempts to eradicate it are affected by the movement of peoples across Africa. They are potential reservoirs of new malaria infections, (Prothero, 1965:49-51). In general, rural Africans do not take malaria prophylaxis; they do develop some immunity against the disease if they pass the age of 5 years, before which time the mortality rate is very high. Although death (in adults) does not generally result from attacks of malaria, it is a debilitating disease, lowering resistance to other infections, which may well prove fatal, (Prothero, 1965:15).

The ordering of the 'closed district' by the Passports and Permits Ordinance of 1922, preventing free access to Darfur to traders, effectively reduced the flow of information and news to that part of the world. Traders needed a permit to enter the area to sell their goods and, undoubtedly, the officialdom was prohibitive - intentionally. Those Fūr who went to work in the Gezira stayed away for months or years. During fieldwork elderly informants spoke of their feelings of isolation from the rest of the country; they had been used to the regular passage of travellers and traders through their country and suddenly found it greatly reduced. Before the establishment of the Gezira, probably relatively few Fūr had travelled to any great extent outside the sultanate, even to make the pilgrimage.

The cross roads situation of Darfur brought people to the area from different parts of Africa, with their own customs and ideas, differing in varying degrees from those of the Fūr; it ensured an 'open-mindedness' constantly refreshed by meeting new faces and ideas from north, west and east, and occasionally also from the south. The Sultanate gave the Fūr themselves an identity and a history. The twentieth century marked the beginning of a new era in Darfur with the loss of their dynastic rulers and their assimilation into a country under foreign rule, which then attempted to isolate them from the outside world. With Independence in 1956, the Fūr were introduced to Western technological ideas, with which they have been keen to experiment, particularly in the fields of agriculture and medicine - veterinary as well as human. They were also eager to build schools for both girls and boys and (utilizing the indigenous self-help schemes) have built many primary schools in remote villages. Gradually secondary schools were added, but the queues of those wanting to attend primary school are still too long to be coped with.

All Darfurians who travel, pilgrims, traders, students and labourers, take back with them their newfound ideas and beliefs and stories of the world beyond the borders of Darfur. Naturally, they recount their experiences to their friends and relatives. Talking is a great pastime among the Fūr, they indulge in little else (except for those who drink the local beer (merīsa) when they are not actively working about the homestead or farm. There is nothing they enjoy more than the countless retelling of personal histories, listening to each as if it were for the first time.

The Fūr have known the ravages of epidemic disease over the years and have been witness, in the life-time of today's middle-aged adults, to the favourable effects of much of modern medicine in the eradication and control of many previously fatal infections. They now hopefully await the development of the rural areas and the benefits which they believe can improve the quality of life.

2.11 SUMMARY

To sum up, in this chapter I have given an outline of the history of the Fūr and of their relations with the outside world, describing the Islamization of the area and the resulting open-ended world-view of the Fūr. In the next chapter I concentrate on the internal organization of Fūr life.

Chapter 3

THE FÜR: ECOLOGY AND SOCIAL ORGANIZATION

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3.1 INTRODUCTION

When history emerged from the veil of tradition in the land surrounding Jebel Marra, it was the Fūr, led by the royal Kayra lineage of their aristocratic Kunjara clan, who became the dominant group. Although in the past the Fūr sultans ruled over the territory stretching into Kordofan, the Fūr as a people never settled so far afield from their mountain homeland and the area to the southwest of it, along the Wadi Azum.

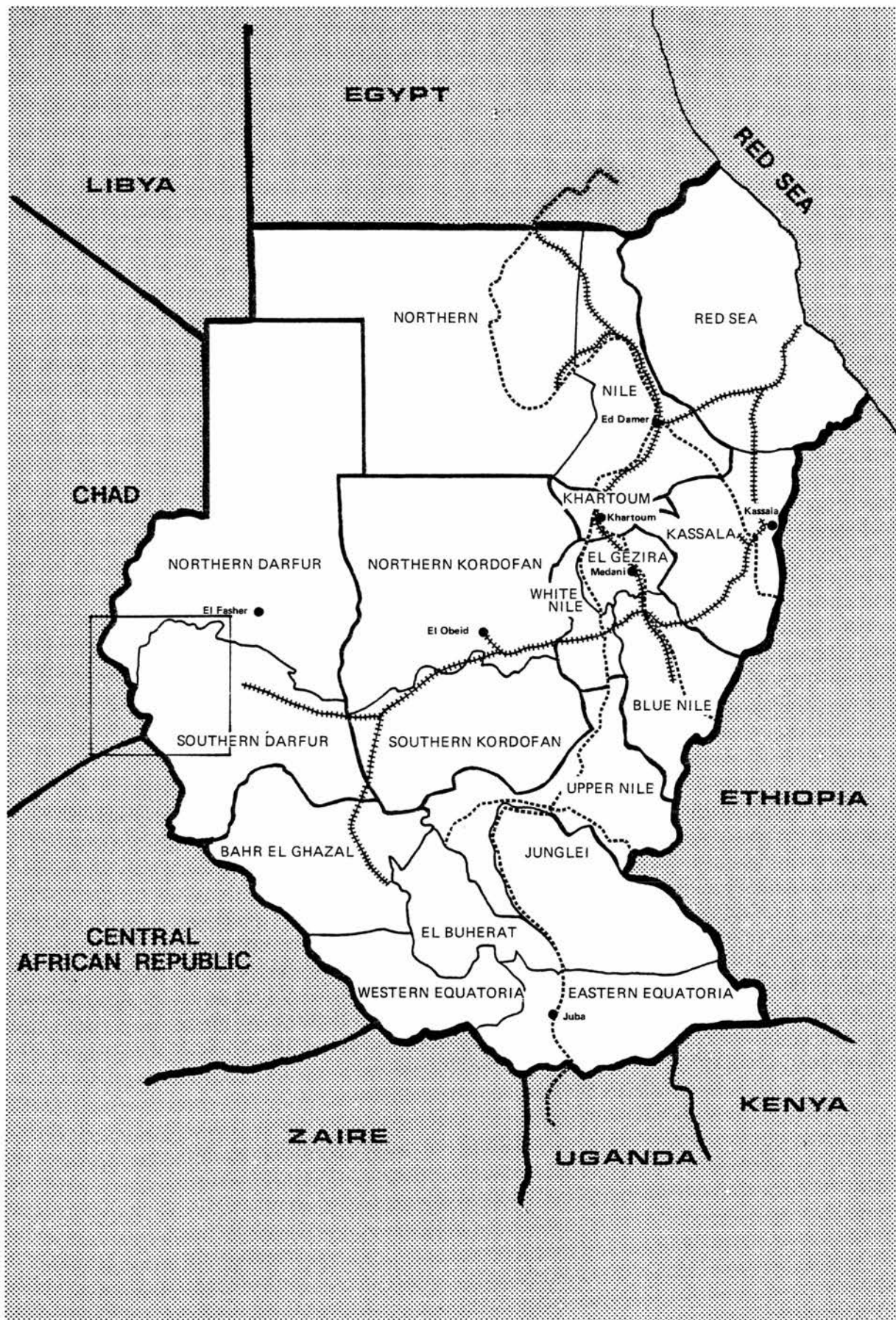
In many ways, the land and its particular geographical configuration was instrumental in shaping the history of Darfur, in defining its frontiers and in providing the means for settled agricultural existence. The land and its produce, dependent upon seasonal variation, are the most important environmental factors which today influence the lives of the Fūr. An outline of their environment is necessary as a background, against which can be portrayed the social life of the Fūr.

3.2 GENERAL GEOGRAPHY AND ENVIRONMENT

The Region of Darfur, the westernmost province of the Democratic Republic of Sudan, (see Map 2) is an area of great contrasts in its geography and ethnic composition. In the days of the sultanate, the boundaries of Darfur were not constant due to the fact that the sultans invaded and conquered much of the land adjoining Darfur. Today the boundaries of the region are officially within the area enclosed by latitudes 9°N and

20°N and longitudes 22°E and 28°E, an area of some 490,000sq.km. but it is the natural features of the area which really form the most effective demarcation of the land. To the north, stretching for hundreds of miles, lies the Libyan desert, with its southern border threatening the 'coastal' (sahil) zone between the desert and the savanna pastures. To the south the region is bounded by the Bahr el-Arab and the tsetse fly which determines the most southerly extent of the nomadic Arabs and their cattle. To the east are the sand dunes of the qoz and only to the west, into Chad, lie similar lands. These have always been the source of disagreement in the past between Darfur and Wadai, the neighbouring sultanate, in the eastern region of Chad.

The central feature of the region is the mountain range which runs north-south, and which has been the stronghold of the Fūr sultans for centuries. Jebel Marra (the Marra mountain) rises to over 3,000m. and forms a watershed between the Nile and Lake Chad. The surrounding plains are some 900m. above sea level and consist of gently undulating country bisected by many large, seasonal water-courses (wadis) and small local streams (khors), which drain from Jebel Marra. The wadis and khors are dry for the greater part of the year but flow swiftly during the rains.



----- wadi
 +---+ railway

MAP 2 SUDAN
 Provincial and Regional Divisions

The mean annual rainfall in Darfur is low and varies from 300mm. (12in.) in the inhabitable part of the north, to more than 700mm. (28in.) in the southern part of the region; further north there is as little as 12mm. (-1in.), (Barbour, 1961:149). According to Winstanley (1973:193), the isohyets in this area have shifted southwards by about 1km. a year during the last 20 years, the significance of this being that a shift southward of the climatic zones of 1° of latitude only, in 100 years means a decrease in rainfall of some 40-50% (*ibid.*194). The year 1973 was one of disastrous drought in the lands south of the Sahara but since then the rainfall has recovered to some extent, (Adams & Hales, 1979:760). However, the long term downward trend of rainfall which began in the 1920's may continue for another 50 years, (Winstanley, 1973:194).

Jebel Marra has a much higher rainfall than the surrounding plain, with up to 1000mm. of rain falling on its higher slopes. The northern and eastern part of the mountain are noticeably dryer than the western and southern, which can support a much greater variety of vegetation and is much greener in consequence. However, the rainfall on Jebel Marra has also decreased, like that of the surrounding plain, and informants told of almost perennial mountain streams flowing in their youth (during the last 30-50 years), which nowadays only flow during the rains.

Barbour has divided Western Sudan into 4 main sub-regions, but only 3 of them are relevant here, the fourth being the Nuba Mountains, (Barbour, 1961:148). To the north is the semi-desert, to the south is the area of stabilized sand dunes known as the qoz and to the west is the more fertile region where the majority of Darfurians live. For the purpose of this ecological outline of Darfur, the region can be described under more localized zones - the north and south, the lowlands to the east and west of Jebel Marra and the mountain region itself at the heart of Darfur.



1. TERRACED HILLSIDE FIELDS, JEBEL MARRA.

The northern zone consists of stony ground with sandy patches; it is capable of supporting only the thorny acacias towards its northern limits and short grasses further south. This zone blends into the desert in the far north of Darfur. The landscape tends to be flat but is broken in places by sharply rising groups of craggy mountains. The people of this zone are nomadic or semi-nomadic camel owners in the more northerly parts and sedentary and semi-nomadic cattle owners towards the south. The sedentary people also keep sheep, cattle and goats and they cultivate vegetables, grain, citrus fruits and dates where possible. In winter tobacco and onions can be grown.

To the eastern side of Jebel Marra is the area of gently rolling sand dunes, the qoz, where grasses, shrubs and small trees grow according to the water supply but increasing in abundance towards the south. In this area deep wells have been dug and reservoirs constructed to store water. The most impressive features of the landscape in this part of Darfur are the tebeldi (baobab) trees¹ whose huge trunks, sometimes up to 8 metres in diameter, are hollowed out and used for water storage.

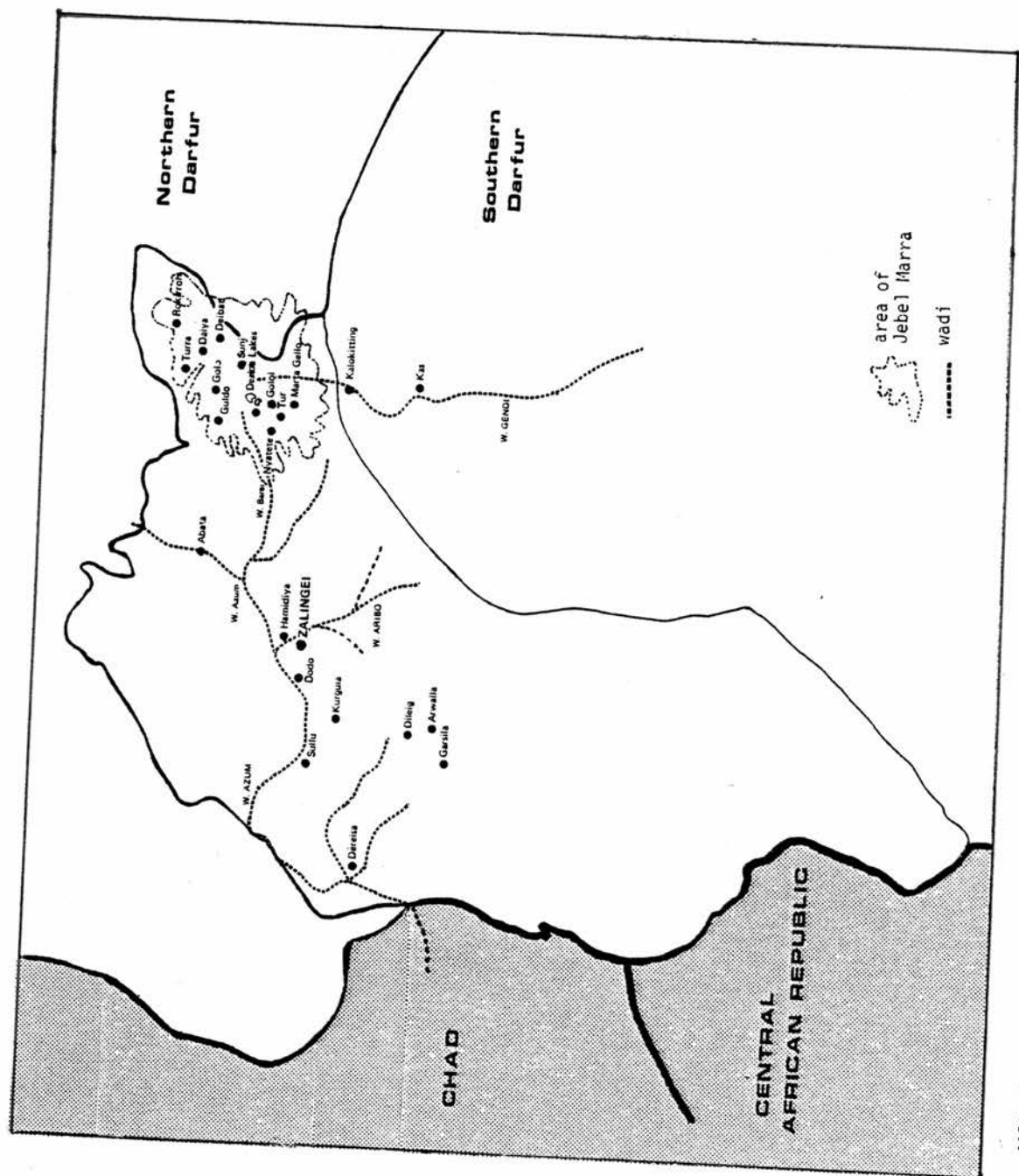
In the southern zone there is a general improvement in climatic conditions and water is less scarce. This zone stretches south to the Bahr el-Arab, which forms part of the boundary of Darfur with Bahr el-Ghazal Province. The vegetation is more luxuriant and provides cattle fodder all the year round. However, the cattle have to be taken north in the rainy season because of the tsetse fly. During the northerly migration, crops, especially grain, are grown in the home territory.

1. Adansonia digitata, (L).

To the west of Jebel Marra and south-west along the Wadi Azum lies the homeland of the lowland Fūr, (see Map 3). It is an area of fertile alluvial soil where water is available a few feet below the surface of the wadi beds in all but the driest weeks. Several crops are grown in this area, grain, citrus and other fruits, vegetables and groundnuts and the farmers also keep a few cattle. The landscape has a generally greener and fresher appearance and supports more wild life than the other zones, particularly birds, gazelles and monkeys. However, despite the fact that this zone is in marked contrast to the other zones in Darfur, it has nevertheless suffered due to the decrease in rainfall generally throughout the whole region. An increasing population has led to large areas of land being cleared for cultivation and with tree-felling for other purposes, these factors combine in degrading the environment.

Jebel Marra must be considered as a separate zone as its altitude gives it an environment differing from much of the surrounding lowland. The mountain was the heart of the Darfur Sultanate and the home of the majority of Fūr, but nowadays it seems the population is greatly reduced, if the many ruined villages and extensive terraced cultivation sites are evidence of former residence.¹ The slopes of the mountain support a vegetation of grasses, acacias and mixed forest, grading upwards into olive and fig trees and mountain flora. The perennial

1. This was noted by personal observation and is also recorded by Barbour (1961:154) and by O'Fahey (1980:2).



MAP 3. Western District of Southern Darfur Province
(enlargement of area on Map 2)

streams historically associated with Jebel Marra are not now much in evidence except in the rainy season. Near the highest peak are two lakes, situated in the floor of the extinct volcano, at a height of about 2,400m. one is salty, the other is said, by the Fūr, to be sweet. The system of terraces is very extensive, covering every possible surface of the mountain, in order to prevent erosion of the soil and also to make irrigation possible. The majority now are only rain irrigated. The Fūr villages nestle in the hillsides, almost camouflaged by their natural colouring and stone and thatch construction. Nowadays they are built near to water supplies rather than on strategic hilltops. Again, wildlife is more abundant than in the lowlands and most people keep a few domestic animals, goats, cattle, donkeys and camels. The large Dongola donkeys are preferred for riding (by men) and they are very sure-footed and strong; the smaller brown donkeys are used by women and for transporting goods.

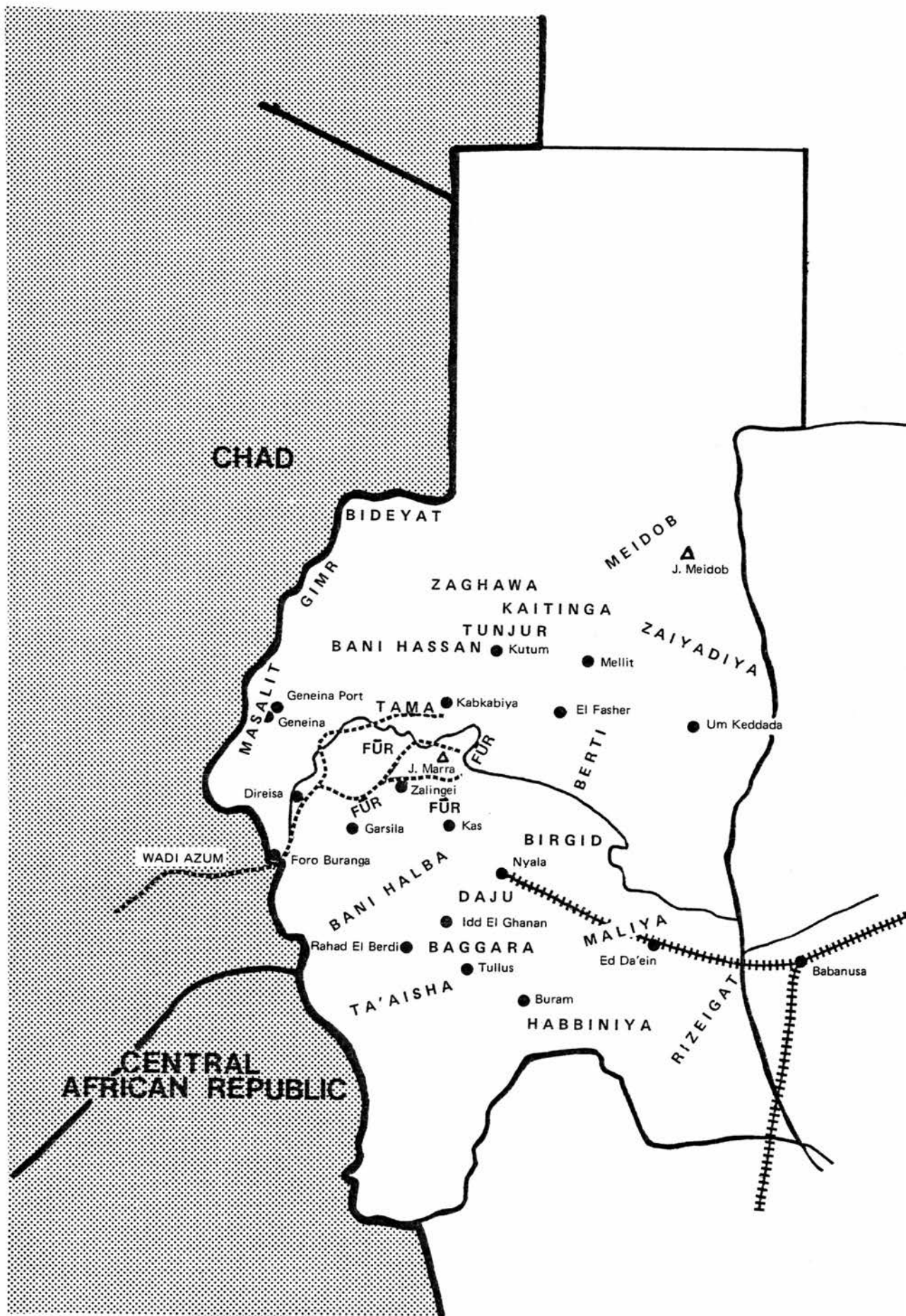
In 1978 a major development plan was inaugurated for Southern Darfur and the Western Savanna Development Corporation was formally established to make a comprehensive effort to halt the decline in traditional farming techniques, to improve crop production, and to modernize out-dated land rights. This has to be accomplished in the face of a fairly rapid increase in the population and a change in the climate, both of which are reducing the long-term carrying capacity of the land, (Adams, 1975 and 1980). The Jebel Marra Project which has bases in Zalingie and Nyrtete, in the foothills of Jebel Marra, has been incorporated into the larger organization now, but has been in existence since the mid-1960's.

3.3 FÜR NEIGHBOURS

The peoples of Darfur number around 2,000,000¹ and may be divided into three main groups - the sedentary indigenous people, the nomadic and semi-nomadic non-Arabs and the Arabs. Altogether there are some 30 distinct ethnic groups, speaking 14 different languages, (Arke11, 1951:52). Map 4 shows the distribution of the major groups of people in Darfur.

The Für, Daju, Tunjur, Berti and Masalīt are sedentary and indigenous peoples, of whom the first three are particularly linked in the traditional history of Darfur. Of the Für, more will be said later. The Daju and Tunjur are now relatively few in number with only their traditions remaining to tell of their former power. The Daju now live around Nyala and speak their own language, the Tunjur are found around Kutum in Northern Darfur and speak only Arabic as do the Berti who live around Mellit and towards Um Keddada. The Masalīt occupy the westernmost part of Darfur and also have their own language, the Gimr are further north along the Chad border and speak only Arabic. All these people nowadays speak some Arabic, the majority of men are bi-lingual. They grow grain, mainly millet (dukhn) and breed cattle and sheep. Western historians believe these groups to be indigenous but they themselves all claim an Arab origin in their traditional histories.

1. Population of Darfur given as 2,180,570 in 1973 (Africa South of the Sahara, 1982-83).



----- wadi
 +++++ railway

MAP 4 DARFUR REGION
 ethnic groups neighbouring the Fūr

Of the nomadic or semi-nomadic neighbouring groups, the Zaghawa are probably the most widespread. They inhabit much of north-western Darfur, have their own language but speak also Arabic, as do the Meidob, in their rather isolated area around Jebel Meidob to the north-east. Despite their isolation from other peoples in Darfur, the Meidob are visited by nomadic herdsmen who go to collect salt from the crater in the southern end of the mountain. They also have their own language. The Zaghawa and Meidob are both semi-nomadic and keep cattle, sheep and goats and some camels although the country is not so suitable for camels as that further east.

The Arabs of Darfur are camel owners in the north, agriculturalists in the eastern part of the region and cattle owners in the south. The Zaiyadiya is the largest group of camel nomads in Darfur, inhabiting the north-eastern semi-desert region between the Berti and the Meidob and travelling south into the goz at the beginning of the rainy season to find the new grazing areas. When in the northern part of their migration, the Zaiyadiya camp within reach of wells where they can water their animals. The camels graze within the general area of the wells, sometimes as far away as 80km. and are brought every seventh day to drink during the summer. During the winter months there is sufficient vegetation further north, in the region of Jebel Meidob, and they do not need water for a few months.

The sedentary Arabs, the Misseriya and Ma^Caliya, both related to the Baggara nomads of Kordofan, and the Beni Fadl all cultivate grain and vegetables and keep sheep and goats. They irrigate their crops

from the rain collected in reservoirs situated to the eastern side of the region.

The Baggara cattle nomads of Darfur are of four groups, the Rizeigat, Habbaniya, Ta^Caisha and Beni Halba migrate from their homeland only when they are forced to by the tsetse fly in the rainy season, when they move northwards to the goz, and by the lack of water, when they move southwards as far as the Bahr el-Arab. While the herds are to the north, crops of grain are sown and tended by those who do not migrate with the herds or by hired cultivators - usually westerners. The women bring milk and milk products to the markets to sell or to exchange for grain, particularly in the winter months. There are some groups of West Africans who have migrated to western Sudan and they migrate with the Baggara and also cultivate. Their base is near Tullus, south of Nyala.

In the Western District, Tama, Daju, Birkid, Beigu and Masalit have all lived among the Fūr for generations. The Tama men are often blacksmiths and this has been their traditional occupation in the times of the sultans, when their wives were potters. Nowadays many women make their own pots, except in the urban areas, where they can be bought in the market. The Tama tend to speak both Arabic and Fūr. There are other small groups of sedentary Fellata living in some villages and in Zalingie. An important group are the 'Jellaba', merchants from Northern Sudan's riverain areas. Many families have been in Darfur for as long as two centuries. The nomads are also often to be found in the market of Zalingie, making it a meeting place of many peoples of widely varying life styles.

3.4 LOCAL GOVERNMENT IN DARFUR

The majority of Fūr live in mountain villages in Jebel Marra and further north in Jebel Si and on the plains to the south and west of Jebel Marra. Their villages in the lowlands follow the course of the seasonal rivers, the main one being the Wadi Azum, where the soil is more fertile and where water is more easily obtained. This part of Darfur, with the exception of Jebel Si which is in Northern Darfur, is known as the Western District of Southern Darfur, the administrative centre of which is at Zalingie, a small multi-ethnic market town.

Before the Peoples' Local Government Act of 1971, the territory of Darfur had been divided into 'lands' (Ar. dars) each dar being administered by a shartai. In the time of Sultan Muhammed el-Fadl (1801-1838) the system of administration had been co-ordinated and fixed boundaries settled; Darfur was divided into north, east, south-east and south-west regions, and later also a western region. The Fūr lived mainly in the south-west (dar aba dimang) and the south-east (dar aba umo), each ruled by its respective title-holder. Under each of these title-holders were the shartais,¹ then cumdas² and shaykhs. Each shaykh was in charge of a village or group of villages where he was the head of the leading family and it was his duty to render justice and to collect the taxes which he then passed on (keeping his own share) to the cumda who collected from several shaykhs; the cumdas and shartais paid their dues to the magdūm³ who had to make sure that the sultan

1. shartai (Ar.) }
2. cumda (Ar.) } various title holders in the sultanate hierarchy.
3. magdūm (Ar.) }

received his dues from his subjects. Ali Dinar rearranged the system slightly to increase the efficiency of tax collection and abolished the position of magdūm, replacing it with several agents (mandūbs), officials who collected the dues of each district. With the 1971 Act, all these official posts were abolished. However, many of the incumbents of the redundant posts then became elected as members of the Peoples' Councils. The titles of ḥumda and shaykh remain in the administrative system but their posts are also open to election. They are basically revenue collectors. Many of them are members of the families who had title and privilege in the times of the sultans.

Following the 1971 Peoples' Local Government Act, and the abolishing of the system of Native Administration, government officials became responsible to the elected rural, town and district councils and through them to province councils and to the governor of the region, who holds a ministerial position. The local government councils are made up of officials and elected members, 25% of whom must be women, if this is feasible.

Among the older generation there is still a sense of unity between the inhabitants of a dar, especially in Jebel Marra, and there is much movement between the villages with regard to markets. However, an individual's village and the area in which he has rights to use the land, are his main points of reference and identification.

3.5 FŪR VILLAGES

The Fūr are rural people and even those who live in the urban neighbourhood described below, are basically villagers who happen to live on the edge of the small town, enjoying the facilities which the town can provide but still tending to regard their neighbourhood as the village it once was. It should be pointed out here that although Zalingie is the Local Government centre and has a daily market, schools and a small hospital, it is very rural and its population was estimated as 13,485 by the 1964/66 survey carried out by the Department of Statistics.¹ The present study does not include a detailed survey of urban Fūr living in a large town, such as el-Fasher, Nyala or Khartoum but a number of informants were interviewed in each place. There are Fūr migrant labourers in Khartoum and the Gezira towns, but few Fūr residents of other towns in Sudan.

Fūr villages vary greatly in size and may have as few as 100 inhabitants or as many as 1000 or more. The village usually has a main central pathway with several side paths leading to it; these may connect up with other secondary paths or end in cul-de-sacs. The cul-de-sacs serve clusters of homesteads, often of related families, but some homesteads have their entrances on the main or secondary pathways. (The term 'household' is used to denote the group of houses of the nuclear family; the term 'homestead' is used to denote the area bounded by the outer wall or boundary fence. Thus, two or perhaps three households - of parents and married daughters - could be within the

1. Population and Housing Survey 1964/66, Darfur Province.
Department of Statistics, Khartoum 1968.

one homestead. There may be dividing walls within the homestead, but not built to the same sturdy specifications of the outer boundary walls.) Each household generally consists of a number of single-roomed cottages within the boundary fence or wall of the homestead. Each household is the home of a married couple, a divorced or widowed woman or a wife in a polygynous marriage. Thus, it is the woman and her children (if they are still young) who form the basic residential unit, with the husband/father a regular visitor (in the case of a polygynous marriage) or, more commonly, a permanent resident. If there is a daughter marrying, her first home will usually be within the homestead of her parents, but separated from their household, sometimes by a small fence. After a year, the young couple may decide to move to the husband's parents' home or village, or to set up home in a neutral place. It is not uncommon to find that two or three sisters, married and with their own families, have their homes in adjoining homesteads, especially in the rural areas. The boundary fences here are not so static as those in the urban area, for there is more free land for expansion. Also, villages themselves are not static. This means that if there is not enough room within the original parental homestead, and sisters wish to live in close proximity with their families, they can either expand the total area which can then be reallocated for each families' needs, or move to where there is available land.

Women, as is common in most parts of the world, tend to outlive men and for this reason as well as the fact of polygyny and divorce, and because men migrate to find wage labour and are often absent as muhajarīn, there are always more women in the village than men.

Fūr children are often to be found in the households of women other than their mothers, on a semi-permanent or regular basis. The children of one man, if he is polygynous, will often be found in the household of their half-brothers and sisters if the houses are nearby, even when they are still quite small. If a man has a rural and an urban wife, or one living in close proximity to a school, she may look after his school-age children during term-time. If co-wives are friends, as some are, and they live near together or in the same homestead, they become almost interchangeable as baby-minders while the children are still physically dependent. Fostering of children within the family is not uncommon, particularly if a woman is childless or her children have grown up and left home. It is also customary for a father's sister to take one of her brother's sons if she has none of her own.

Fūr villages are not usually very permanent groupings of people, though they may last a few generations. People often move on when fertility of the land decreases or if the water supply becomes problematic. A man or a group of brothers, or unrelated friends, may set up their new houses on a chosen site agreed with local shaykhs, and the new village is established. Over the years, daughters marry and set up their houses uxorilocally. New people may join the nucleus of the village at any time; their joining is not necessarily dependent upon kinship relations.

3.6 FOOD PRODUCTION

The subsistence economy of the rural mountain Fūr has been analysed by Barth (1967) using concepts of spheres to depict the flow of labour, beer

and grain products in one system and cash, cattle and material goods in another. Haaland (1972) has described how some lowland cultivators have taken up a nomadic existence because they can invest their money in cattle in a way that cannot be done with crops, because land and labour cannot be bought with money.

This section seeks only to describe the production of the food items eaten by the Fūr and to show how they obtain the necessities of life which they do not grow and cannot produce for themselves.

A married couple do not as a rule, work together as each has his or her own land on which crops are grown. This land is inherited from parents and grandparents or held as usufruct, by negotiation with the village shaykh or Cumda. Some individuals have land in several different areas and each piece may be more suited to growing a particular crop, depending upon irrigation possibilities. On the terraces of Jebel Marra bullrush millet (dukhn) is grown and relies upon rain in the months of May to August, during which time it is constantly weeded, until the harvest in September and October. Near to the main wadis and lower down the slopes of the mountain, where irrigation is possible, onions, small tomatoes, ladies' fingers, garlic, tobacco, groundnuts, karkadeh¹ are grown as well as spices. Some tomatoes do grow also on the terraces. In the areas of better water supply orchards are being developed, where citrus trees grow well (limes, oranges and lemons), as also do mangoes, guavas, pawpaw and bananas.

1. Hibiscus sabdariffa, (L) the calyx of which makes a refreshing drink.

Barth (1967) notes that each adult Fūr is an independent unit, economically. The spouses do not have comprehensive rights to each other's labour, excepting the wife's duty to cook for the husband and children and to brew beer, and the husband's obligation to provide clothing for his wife and children. Barth also stresses that the grain of each spouse is kept in separate grain stores and used separately, that of the wife for feeding herself and her children and that of the husband for feeding himself and for the brewing of beer for himself and his guests, (Barth, 1967:151).

From my own observations in Barei, the situation was rather different. In some families at least, and certainly in most households where the men are monogynous, one grainstore is used at a time and any surplus carried into the next season can then be sold to buy some tea or sugar, perhaps, or cloth for clothing. Beer, too, is made from the store currently in use. Whether this is a trend or a peculiarity to Barei, would be difficult to estimate.

Among the families of Barei there was much co-operation with farming procedures. People work their own fields as far as they can and then families group together to help each other when necessary. Men and women work alongside each other and as the children grow up, they too are given work to do in relation to their size. Girls of 5-7 years look after babies while their mothers are working, older sisters and brothers clear and carry or herd the cattle. Qur'an school pupils help farmers and also their own teacher in return for food.

The technique of farming cereals and vegetable crops among the Fūr is roughly similar, regardless of the crop. The land must be turned over and prepared after clearing of grass and other unwanted plant material. The main implement employed for turning the soil is a short-handled hoe and it is used by the farmer bent at the hips with straight back and legs. This working position, which would be regarded by physicians and orthopaedic surgeons in the West as being highly prone to initiating and exacerbating low back problems, is in fact, responsible for aches and pains among the Fūr. However, they regard such aches and pains as a normal part of everyday life, something to be expected, and not to be complained about.

An axe is used to cut down large shrubs and small trees which would impede the growth of the crops, a small knife is used to harvest the heads of the grain for drying and then a wooden flail is used for threshing on a hardened earthen floor. The grain is collected and stored in large grain stores either outside or inside the houses.

When the need arises, extra labour may be summoned to help finish tasks on time or simply because the work needs many hands. This extra labour may be brought in by an individual from his immediate family, his near kinsmen and neighbours or on a much larger scale. Among the family, the mobilization of labour is an activity which will be mutually reciprocated; on a wider scale where mutual reciprocity is less likely, the Fūr have an institutionalized means of co-operative assistance, the towisa. Those who come to give their own labour are repaid with sustenance. When labour is required, an individual lets it be known

that he is providing food and beer (or just food if he does not drink alcohol) for the day. Those who wish to (and most people do), come to his farm with their hoes and all work in unison, singing through the day.

3.7 MARKETS

Markets are such a significant feature in the life of the Fūr that they must receive mention here. Throughout rural Darfur there is a system of weekly and twice-weekly markets. Each market is held either a very short distance from the village or in the central part of the village, around which households have grown up. Few markets are of the latter type in Jebel Marra, mostly being of the type where traders come, spread out their mats and sit down with their wares before them. The village women also take along their items for sale and sit a short distance from the men to sell their goods. The markets where the traders and some merchants have lock-up buildings are much bigger, and function twice-weekly or for two days consecutively. There is also a section in Zalingie market for people without stalls to sell their goods, although the market is of the permanent type; it functions every day of the week and on a much bigger scale than the village markets. In it are many brick-built shops. As in most large markets, there is an area for the blacksmiths and leather workers.

For most villages there are several markets they can go to every week, each within about two hours walking distance - some 5-10km. (3-6 miles). During the times of little agricultural activity, the

markets form an important focus of social life, where relatives and friends can meet to talk under one of the shade roofs or in the shadow of a large tree, or in a nearby house where the local beer (merīsa), is known to be brewed. Although many, perhaps a majority, of the people drink, merīsa is always taken somewhat secretively and among friends, never in the open market place. This is presumably because of the Islamic proscription against alcohol. Whatever the type of market layout, women tend to place themselves in the central area with their produce vegetables, grain, dairy produce (mainly brought by visiting Arab women) and fruit around them. Market stalls, and lock-up shops owned and used by the men, are built around the central area or they erect shade roofs or sit under trees. Their goods are more varied than the women's, ranging from spices, perfumes, soap and household items, to farm implements and brightly coloured cloth (often man-made fabrics).

Markets form a very important part of Fūr life. The people depend upon their visits to neighbouring villages on market days for a major part of their contact with kinfolk, friends and acquaintances, as well as for buying and selling. Nowadays, there are community health workers in several of the Jebel Marra villages and so on market days people combine their visit with one to the dressing station or primary health care unit.

3.8 DESCENT AND KINSHIP

Generally, the mountain Fūr can trace their genealogy for 6-8 generations. Those in the mountain villages seem to be more concerned with their ancestry than those in the urban neighbourhood studied, where fewer generations are usually recalled. This is, perhaps, due to the closer links felt by mountain villagers with the sultanate and its former capital of Turra, where most of the sultans lie buried.

The founding fathers of Barei village were the fathers of the present older generation, but people trace back past them to the original feqi and his son, who came from Kordofan to teach the people Islam, at the invitation of Sultan Musa Sulayman. The feqi eventually returned to Kordofan but his son remained and married a Fūr woman. Their son was given land in the area by the sultan and this land remains in the hands of the same family today. The feqi and his son were Jawāma Arabs, but their sons married Fūr women. Eventually it became possible for young men to marry their FBD MBD FZD or MZD, (the 'ideal' marriage partners for the Fūr) though not all do so nowadays.

The people of Azumiya are, of course, not all related, as indicated earlier, as one would expect in a small market town. However, many of them do claim membership of the founding family. When the head of the family moved to the present site, some 75-80 householders who were related to him also moved.

There is, according to Haaland (1972)¹ and Abdel-Jalil (1980) a patrilineal bias in general rules of descent, where people say that the

1. Haaland, in an appendix to S.R. O'Fahey's thesis, 1972.

father is the 'bone' and the mother is the 'flesh'. This implies the relative statuses of the paternal and maternal relations, the male being more permanent and lasting through time. The bias was most in evidence when blood money was to be paid and, although the patri-kin played the main role, the matri-kin were also involved in the contribution towards the blood money. Distant kinsmen were also involved in such transactions, (Abdel-Jalil, 1980:66).

Marriage transactions bring about similar involvement of the two sets of kinsmen, the patrilateral group playing the major role again.

Where land is concerned, the old customary codes still operate, although officially all land belongs to the state. During the times of the sultans, many families were given land and this is held in the name of one person who represents the nuclear family, or larger category of close relatives recognizing the original recipient as their ancestor. Usufructuary rights are granted to individuals by the family representative, a duty which is passed on to one of his heirs at his death. In the mountain villages there does seem to be a more or less permanent grouping of people who use the term worré (F) to describe themselves and it is they who are concerned with the land rights. They are led by the worrentubu, who is an individual of significance in the community and a 'reasonable man' (in the legal sense). This title is hereditary within the family but need not go to the eldest son of the previous incumbent. The worrentubu did not fit into the hierarchical system of government at any time. During the times of the sultans, they would deal directly with each worrentubu, according to

informants. Within the mountain region, many villages consist of a single worré. In the lowlands and in urban areas, the term worré is not so precise and is not remembered so well. Often informants gave very conflicting views on the subject; some believed the term to mean the divisions of the entire ethnic group, the Fūr, while others indicated that the term was used to delineate the groups within the main branches of the Kayra (royal) branch, the Kunjāra (aristocratic) branch and the 'miskīn' (Ar.) - literally, the 'poor ones' - of whom none were ever encountered. As the Kunjara were so prolific it is likely that almost every Fūr can claim some degree of relationship to them, at least affinally. Some individuals replied that the Kayra, Kunjara, Tunjur and Temurka were all worrena (pl.). Haaland suggests that the term in the lowlands means simply 'kinsmen', (1972:46).¹

Abdel-Jalil, agreeing with Haaland over the intricate nature of the named groups among the Fūr, points out that recognition of the worré is arbitrary and dependent upon geography and political factors, (1980:67). He also maintains that the majority of Fūr do not remember their ancestors further back than their grandfather's father, (*ibid.*).

As far as corporate grouping is concerned, it would appear that this is more or less lacking among the Fūr, at least nowadays. The blood feud was the only situation which provoked involvement of a large grouping for joint action. There are no rituals of a communal nature. It is only the extended family, the worré of the mountain peoples, which

1. Haaland uses the spelling orri, O'Fahey, orre, and Abdel-Jalil, orré but for my own area, the local pronunciation seemed to be more as given - worré.

shares the interest in the land and in marriage arrangements. Inheritance of moveable property is basically organized according to Islamic shari^C law. Fruit trees in mountain villages seem sometimes to be given to the preferred individual while the owner is alive and this may not be in line with shari^C law. While alive, both men and women may give the rights to their usufructuary land or gardens to whom they chose, male or female.

According to Barth, the 'main structural features' of the kinship terminology

'seem to be the bilateral nature of cousin terms, siblings' children, grandparents and grandchildren vs. lineal differentiation in parental generation. Further, an almost complete merging of consanguinal and affinal terms, except for Fa-in-law, Mo-in-law, WiSi and WijrBr.

In this latter feature, Jebel usage differs from lowland Fūr, where a more consistent affinal terminology is employed:

jaro = SiHu, WiBr, BrDaHu, SiDaHu

mani = BrWi,

kora = WiSi, WiBrWi, SoWi

Lowland Fūr also has the special term dalang for any junior collateral connected through a female link.[†]

(Barth, 1964:12)

The function of both patrilateral and matrilateral kin in the transaction of a marriage and the payment of blood feud and the fact that husbands are encouraged to live uxorilocally for a year or two after the marriage, even though there is 'a slight patrilineal bias' (Abdel-Jalil, 1980:66), would seem to indicate that Fūr kinship is bilateral.

TABLE 1

KINSHIP TERMINOLOGY

F	<u>bāba</u>
M	<u>ama</u> , <u>iya</u>
FF/MF	<u>uwo</u>
FM/MM	<u>abo</u>
FB	<u>bābang</u> <u>bara</u>
FZ	<u>anya</u>
MB	<u>māma</u>
MZ	<u>khāla</u>
B	<u>bara</u>
Be	<u>bine</u>
By	<u>ditan</u>
Z	<u>niu</u> (m.s.), <u>ditan</u> (f.s.)
Ze	<u>dada</u>
Zy	<u>ditan</u> <u>niu</u>
S	<u>kwe</u>
D	<u>kwe</u> <u>niu</u>
GS	<u>kwen</u> <u>kwe</u> , <u>atiné</u>
GD	<u>kwen</u> <u>kwe</u> <u>niu</u>
GC	<u>atīn</u>
BC/ZC	<u>duing</u> <u>kwe</u>
FZC/MBC	<u>bara</u> , <u>niu</u>
FBC	<u>abang</u> <u>kwe</u>
MZC	<u>khalang</u> <u>kwe</u>
H	<u>duo</u> , <u>dugolong</u> <u>aba</u>
W	<u>duīn</u> , <u>alang</u> <u>koy</u> , <u>iyang</u> <u>kwe</u>
HF/WF	<u>magal</u>
HM/WM	<u>marè</u>
, co-W	<u>wana</u> , <u>ona</u> , <u>wandé</u>
HZ	<u>kora</u> , <u>urūs</u>
HB	<u>kona</u> , <u>mani</u>
WZ	<u>kora</u>

WB	<u>kona</u> , <u>jaru</u>
ZH	<u>magal</u> , <u>mani</u> , <u>kona</u>
BW	<u>urūs</u>

KEY	F - father	e - eldest
	M - mother	y - younger
	S - son	G - grand (as in grandchild)
	D - daughter	co-W - co-wife
	C - child	m.s. - male speaking
	B - brother	f.s. - female speaking
	Z - sister	

Beaton (1968) and Barth (1964) have given kinship terms in their respective works, Beaton's having been collected in and around Zalingie in 1936-7 and Barth's from Jebel Marra villages in 1964. Some slight differences are seen between all three collections. However, there are greater similarities between that of Beaton, collected from Zalingie and that of the present study collected from mountain villages, than this latter study shares with Barth's collection.

Barth gives aba for father, which is one of the terms used for the sultans, while Beaton gives bāba. Both ama and iya are used for mother today, while Beaton says that ama means mother of many and iya means mother of one. Barth gives bara as male cousin and niu as female cousin, whereas Beaton confines these terms to brother and sister, giving circumlocutions for cousin, i.e. father's brother's son is babangbarang kwe de. My informants used bara and niu but also bine and dada for older cousins. It would appear that in affinal relations there

is most variety of names, depending upon degree of friendship between the speakers; a wife may call her husband duo, duong aba or dugalong aba (father of my child), while a husband may call his wife duīn, alang koy (my wife) or iyang kwe if he loves her very much - this means literally 'child of my mother' or 'my sister'. The male affine is usually kona and the female, kora in the same generation, though mani (friend) and jaru which also means 'friend' may also be used, by wife and husband respectively.

3.9 ISLAMIC INHERITANCE

Apart from the inheritance of usufructuary rights to land, which customarily are the concern of the worrentubu, the moveable property left by a deceased individual is divided according to shari^Ca law. In the Qur'an, the shares of parents, children, brothers and sisters are set out, half a man's share being given to a woman, (Sura IV:8-10). However, there is no stated amount to be left to a widow, although it is a duty to make provision for her. Among the Muslim Fūr a quarter of the property is usually assigned to the widow (or widows) and the remaining three quarters is divided according to shari^Ca law. Sons and daughters inherit from both their mother and father. Daughters can inherit moveable and immoveable property, land, trees, animals and money. A man's property is divided by his brothers usually and a woman's, by her husband or her eldest brother.

Apparently, before the Fūr became Muslims, the belongings of an individual were often buried with him. Excavations of some of the sultans' tombs in Jebel Marra have shown this to be so.

3.10 MARRIAGE

The preferred marriage for a Fūr man or woman should be with a patrilateral or matrilateral cross or parallel cousin. One type of union is not preferred over another. The first marriage of a young Fūr man is arranged by his parents; his father asks the father of the girl. However, this arrangement is only apparently in the hands of the male member of the family - in actual fact it is the women who decide and negotiate among themselves. The women encounter the girls in the everyday round of village or urban life and decide upon suitable partnerships. Thus, by the time the young man's father goes to the girl's father with the proposal of marriage, most of the arrangements have been completed.

The first marriage is arranged when the couple are quite young and may take place when the girl is 14-16 years old and the young man about 20 years. However, it is not uncommon for these marriages to break up after a few years. If the young man has completed his time as a muhajar,¹ he may then wish to continue travelling, to keep up with the friends of his wandering days and to earn money. To show his independence, the young man may then decide to find a wife of his own choice. He may divorce the first wife or take a second, depending on his relationship

1. muhajar (Ar.) - emigrant, wandering Qur'an school student.

with the first. According to informants, the preferred course of action nowadays is to divorce the first wife. If the young man has acquired some level of education beyond the primary level, it is usually the case that he divorces the first wife and marries an educated girl, perhaps a fellow student. Such a wife is more likely to be able to fit into the style of life of an educated person, particularly if the man has entered one of the professions. An illiterate wife would seldom be able to accommodate to such a drastic change from her rural upbringing. Without the support of her mother in child-raising and the daily round of farming activities, she would be lost in the busy urban way of life. She would probably have no friends or relatives nearby and her only contacts would be the sophisticated wives of her husband's associates.

Another problem regarding marriage occurs nowadays in some very traditionally-minded families who have not allowed, or thought it necessary, for their daughters to be educated. The sons may have gone to university and grown away from the traditional ideals of the family; when the time comes for them to marry their cousins, they feel that they cannot marry an illiterate girl. This, then leaves the girls in a difficult position, for their families will not consider marriage with a non-relative and their cousins will not marry them. Their only chance then is that an older man will marry them as a second or third wife.

Shaykhs, feqis and other men of substance tend to marry several times. One old shaykh encountered had married 21 wives during his life; at the time of interview he had divorced 19. His wives had all been related to him, the first being chosen by his father when he and his wife were 12 years old. This marriage had lasted for 31 years, however, and

he had eventually divorced the wife for being troublesome and frequently inebriated. Most women are divorced for 'bad behaviour' - in the husband's eyes - for disobeying him and for quarrelling with other wives.

One of the main reasons for having more than one wife is to ensure obedience; each will be jealous of the other and will respect the husband - according to polygynous men. Another reason, of course, is that at some time each of the wives will be pregnant and 'a man cannot be without a sexual relationship', according to my informant. Yet another reason is to ensure a sufficient number of sons to help the father and to look after him in old age. If the man is of significance in his community, he will often be entertaining visitors - relatives friends and dignitaries from other villages - and he will need much food and refreshment prepared. The Fūr do not employ servants and so, unless there are a number of related girls and women in the household, he must have more than one wife. As one shaykh said, 'one wife may be making tea all day' for a large gathering, 'while others will prepare meat, vegetables and porridge' (F. nung, Ar. asīda).¹ 'The number of wives is relative to the importance of the man.'

3.11 MARRIAGE SETTLEMENT

In the past it was always cattle which were given to the family of the bride and to the bride herself, as a marriage settlement. Sometimes money was given as well. Nowadays, it seems that money is given more often but animals may be given as follows:

1. nung (F.), asīda (Ar.) - porridge made from millet, flour, eaten with a spicy meat sauce - the staple diet of the majority of Fūr. Eaten throughout Northern Sudan.

to the bride	1 cow
to her mother	1 cow
to her father	money or a donkey
to her extended family (patrikin and matrikin)	1 ox or the equivalent money

If an ox is given, it may be sold and the money obtained, distributed. However, such prestations are also in accordance with the wealth of the bridegroom and his family. In the urban areas, money is certainly as acceptable as cattle, and in rural areas there is a tendency to give money, especially if the bridegroom-to-be has been able to get work in the Gezira or Khartoum, or one of the provincial towns.

3.12 DIVORCE

Divorce is not uncommon among the Fūr but I did not collect data specific enough to suggest the rate of divorce. Many of my informants (both men and women) were divorced and remarried. Men are often found to be at the stage of being married to one of their wives, having divorced or been divorced by the other. Some female informants were divorced at the time of interview - mainly in the older age groups; some of them probably would not remarry. Young women usually remarry quite soon, especially if their divorce was over another man.

According to the qādi (shari^Ca judge) in Zalingie¹ at the time of fieldwork, there was a fairly high rate of divorce among the Fūr and

1. Personal communication with the qādi.

much wife-beating. However, husband-beating is not uncommon. It should be remembered that Fūr women carry out much physical labour and are very strong as a result. They are quite capable of fighting a man of about the same build and height. Fighting and beating a husband usually results in divorce, but the husband must make arrangements to look after his children, if they remain with the wife. The beating usually results, apparently, from the husband's failure to provide adequately for the family, and/or the threat or fact of introduction of a second wife.

Divorce may also result if the husband goes to work in an urban area and his first wife cannot adapt to the life-style of the town. She may then return to her village and be supported by the husband, who may well marry again in the urban area, or she may be divorced. As has been described above, this is not unusual among rural men who are educated to one of the professions. The first wife is often not able to cope with the urban living, or with the urban wives of her husband's colleagues, who may well be educated too.

3.13 SUMMARY

The institutions by which the lives of the Fūr are organized have been described in this chapter, against the background of the geography and environmental conditions of the Western District of the Southern Province of Darfur. The organization of social life has been depicted from the impersonal and official local government to the village community,

organization of food production and markets, and then to the more personal rules of descent, kinship and inheritance, marriage and divorce, which regulate community and family life. This background of social organization then serves as the setting for the next chapter, which portrays Fūr social life in two communities - one an urban neighbourhood and the other a remote mountain village in Jebel Marra.

Chapter 4

EVERYDAY LIFE IN TWO FÜR COMMUNITIES

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4.1 INTRODUCTION

In order to assess the differences and similarities between rural and urban Fūr life, with particular regard to the medical system, concepts of sickness and its cause, and the behaviour of the sick and those caring for them, it is now necessary to introduce the reader to the two communities in which fieldwork took place. Features of these two communities are described - their homesteads, the domesticated animals they keep, their water supply and sanitation - and data is given concerning a sample of each population. The seasonal and daily routine of Fūr farmers is then portrayed and this is followed by an introduction to religious life, which with the land and its produce forms the cornerstone of Fūr life. This is followed by a more detailed account of the customs relating to the major events of the life cycle among the Fūr.

4.2 A RURAL COMMUNITY - BAREI VILLAGE, JEBEL MARRA

The village of Barei is situated in the northern part of the mountain alongside Wadi Barei. The village is not shown on any official map, but its estimated position would give it an altitude of 1800-2000m. (Map 3 shows the general area). Turra, once the capital of the sultanate, and Daiya, where the small dressing station for the area is located are all within normal walking distance. All three villages

can be reached by landrover or heavy lorry although with some difficulty, for the tracks are not kept in a good state of repair and progress along them is necessarily slow. Rokirroh, where the largest market in the northern part of Jebel Marra is held, is higher than Barei and cannot be reached directly except on foot, a climb and walk along rough mountain paths of some 20km. (12 miles). This walk is undertaken weekly by women who go to the market to sell or to buy goods, which they carry on their heads. For men the journey is easier, for their large donkeys are able to negotiate the steep paths with agility.

Barei was established in 1940 by a feqi, who also established the first mosque. This feqi came with the pupils of his Qur'an school and was soon joined by the families of his relatives who lived in two hamlets nearby. Altogether there were 10 households. The site of Barei was chosen because the Wadi Barei was, at that time, flowing almost all the year round and the area was relatively flat. Other families moved in groups to Barei and at the time of fieldwork there were 89 households.

In November 1979 the total population numbered some 300 individuals according to the estimate of the shaykh, with 154 adults, i.e. householders and spouses. This number was later verified by personal observation, when each household was visited. The adult population consisted of 88 women and 66 men. All girls of a marriageable age living in this village were, in fact, married and the majority of young men were away from the village, either at Qur'an school or working in one of the towns of Darfur, in the Gezira or in Khartoum. (The three unmarried young men encountered in the village in 1980 were on their

annual leave from work in Khartoum.) The disparity in the numbers of men and women is due to the fact that a number of men have two or three wives and there are a number of widows in the village. All the inhabitants of Barei are Fūr and are related to one, if not more, of the three founder families of the village. Two of these main families are in fact related to each other and descended from the first feqi brought by Sultan Musa Sulayman from Kordofan to teach Islam. The son of this first feqi married a Fūr woman from a village near Rokirroh and their sons married Fūr women. Marriage of subsequent sons and daughters to children of siblings of their parents was encouraged though not prescribed.

As Barei village has only been established since 1940, it is not surprising that the majority of its population was not born in the village. However, the great majority of the population comes from other villages in Jebel Marra, most of them within a radius of a few kilometres - such as Turra, Daiya and slightly further away, Rokirroh. Many of the younger people have lived in Barei almost all their lives, despite having been born elsewhere.

TABLE 2 PLACE OF BIRTH: RURAL SAMPLE

Place of birth	women		Rural sample men		total	
	no.	%	no.	%	no.	%
Barei	9	22.0	7	25.0	16	23.2
Elsewhere	32	78.0	21	75.0	53	76.8
totals	41	100.0	28	100.0	69	100.0

4.2.1 Homesteads and houses

The households in Barei are scattered irregularly and apparently haphazardly, on a flat area above the wadi. However, the original quite large plots of land allocated to each family for their homestead have been divided several times now as daughters have married and set up home next to their parents' homes and, thus, clusters of houses have developed. Some newly-weds have had to build their houses on the periphery of the village recently, because there is no longer any room inside.

Each household usually consists of 1-3 (sometimes more) stone cottages with thatched roofs. The walls are constructed of fairly large stones, after the manner of dry stone walling, with smaller stones to fill in the gaps if necessary and then the inner walls are mud-plastered in an attempt to keep out the worst of the winter cold. The temperature can be as low as $2-3^{\circ}\text{C}$ in the mountain (occasionally 0°C has been recorded). Each cottage is a single room, round or square, occasionally rectangular. The central cottage of the homestead is that of the wife/mother, and this acts as the kitchen, housing for the grain store, general family meeting place, shelter and the sleeping accommodation for the mother and small children. This cottage in most households has a smokey atmosphere, from the almost constant fire, which has no chimney. The high thatched roof is blackened above the area of the hearth. Drying meat adds to the aromas of the place.

The cottage of the husband father is not used to the same extent as that of his spouse but is used when he has male visitors. He may eat there with his older sons, or under a shade roof. If there are older girls and boys, they will have small cottages as well, that of the boys

being used for male guests, female guests tend to stay in the wife's cottage. People often sit outside their houses at night, especially when there is moonlight, as they do not normally have fuel for lamps, or candles. The floor of such cottages is flattened and hardened earth, sometimes with a rush mat covering. Furniture is minimal and may consist of locally made wooden beds, occasionally metal beds, and small carved stools.

Each household is surrounded by a fence of millet stalks, reinforced with thorny acacia branches and, sometimes, rocks. Within the confines of the boundary fence is the cattle corral, constructed of large, sturdy branches interwoven with acacia thorns to keep out any night predators.

4.2.2 Cattle and other animals

In the majority of rural households, the cattle are corralled next to the houses when they return at night from the pastures. They are fenced in with stout branches and acacia thorns to prevent wild dogs and wolves attacking them. Chickens perch on the corral fence at night, but have the run of the homestead during the day. They often run inside the houses, especially in the kitchen, in their search for grain and insects. Pigeons often roost inside the cottages, especially if they are hatching eggs or have young. Goats find their own pasture, often following the cattle, but when they return at night, they sleep where they choose inside the homestead, sometimes entering the cottages if the door is open, from where they are smartly ejected. Horses and donkeys are tethered inside the homestead. Dogs always remain outside and are a law unto themselves.

4.2.3 Water

All water used in Barei must be drawn from one of the wells dug near to the wadi. These wells are about 10m. (30ft.) deep and are lined with rocks. The supply of water was not adequate during the last field-trip to the village (in 1980) due to the fact that it was nearing the end of the dry season (May/June), and people from other villages where the water had completely dried up, were coming to Barei to collect water. Two of the wells were being deepened and this meant that the water was very muddy, only fit for the animals. One well was giving a slow supply of good water. The women spend up to 2 hours in the morning and again in the evening, to fill the family water containers and also to water the animals at this time of year, which is a busy time on the farms as the final clearing of the land is carried out in readiness for the sowing in the early rains.

The water is obtained by lowering shallow vessels made of hide attached to a cane ring, or calabashes on ropes down into the well and waiting while they fill up. They are then hauled up manually - there is no pulley system. The work is done by women. To the best of my knowledge the water obtained from these mountain wells is clean.

4.2.4 Sanitation

Sanitary arrangements are lacking in the majority of homesteads in mountain villages. In Barei, at the time of fieldwork, only one pit latrine had been constructed. The great majority of people in Barei and the other villages of Jebel Marra, continue to go 'over the mountain', preferring the greater privacy afforded them by distance from habitation.

Several individuals had dug pit latrines in Rokirroh and Golo, one of the market villages further south and west, encouraged by sons and daughters who had attended secondary school. The schools of Daiya and Rokirroh have their own facilities and that of Guldo employs the bucket system. The more important market village in Jebel Marra, Nyrtete, on the western edge of the mountain, has more contact with traders and travellers and is the site of a small government office run by a single officer. Sanitary arrangements are more numerous here and are of both types.

Small children urinate and defaecate anywhere in the homestead; the mother or sister covers or removes the evidence. The children are strongly discouraged from excreting inside the house.

4.2.5 Other village features

There is no school in Barei and children go to primary school in Daiya and Guldo and then on to junior secondary school in Guldo or Zalingie, followed by senior secondary school in Zalingie, Nyala or el-Fasher. Two brothers from Barei were just completing their university degrees in 1980, only the third and fourth graduates from the villages of Jebel Marra; the first two were also brothers and had graduated a couple of years previously. Because of the distance to schools, Barei children are always boarders, returning home only during the long vacations.

In Barei there is no village store, but two merchants living in the village do sell such basic items as sugar and tea, if necessary. In general, commodities are purchased in one of the markets which most people

tend to visit each market day. A small market was started recently (during 1980) at Barei; like that of Daiya, it is situated just on the outskirts of the village. These markets start at about 2-3pm and go on until sunset. Women come to them to sell grain, dried tomatoes and fruit; the men who sell goods are more likely to be small traders who deal in such things as sugar, tea, onions, rice, cloth, perfumes, hair ornaments and plastic shoes.

The village has two mosques, the original one, built at the time of the founding of the village, is a large stone building with a very high thatched roof, set among the original houses in the centre of the village. During the last three years there has been dissension among the villagers due to the choice of imam (prayer leader), following the death of the previous incumbent. This has caused a rift and the two factions have still not been reunited. Those who disagreed with the choice, of the son of the previous imam, have built another mosque, towards the south of the village. This disagreement is still one of the common topics of male conversation and has divided families, brothers and cousins taking opposite sides.

4.2.6 Some population data

As already mentioned, the total adult population of Barei in 1979 was 154. A sample of the population selected at random by household has the age and sex structure shown in the table below.

TABLE 3 AGE AND SEX DISTRIBUTION: RURAL SAMPLE

Age group* (years)	women		men		totals	
	no.	%	no.	%	no.	%
- 20	5	12.2	-	-	5	7.2
21 - 30	8	19.5	1	3.6	9	13.0
31 - 40	13	31.7	9	32.1	22	31.9
41 - 50	4	9.8	10	35.7	14	20.3
51 - 60	5	12.2	2	7.1	7	10.1
61 - 70	4	9.8	5	17.9	9	13.0
71 +	2	4.9	1	3.6	3	4.3
totals	41	100.0	28	100.0	69	100.0

(*age group is approximate in some instances)

Factors which influence the population profile include the absence of younger men from the village, either as muhajarīn or migrant workers and that women are married to men at least 10 years older than themselves and they marry from the age of 14 or 15 years.

All the men interviewed were married at the time of interview, 7 were polygynous and one man married his second wife during the last fieldwork visit (1980). This man's new wife was living in her parents' village, while the first wife, who was fairly young but childless, lived in Barei. Quite a number of the polygynous men have both wives living in the village; in one case they live in the same household. It is rare for young women to remain unmarried after a divorce; two were encountered during the survey in the under 40 years group. They were living in their own households with their children.

TABLE 4 MARITAL STATUS: RURAL SAMPLE

Marital status	women		men		totals	
	no.	%	no.	%	no.	%
single	-	-	-	-	-	-
married	33	80.5	28	100.0	61	88.4
divorced	3	7.3	-	-	3	4.3
widowed	5	12.2	-	-	5	7.3
totals	41	100.0	28	100.0	69	100.0

As boys and young adults, men spend a number of years living outside their home community. Some of this time is quite often spent in an urban situation, either in Zalingie, Nyala or el-Fasher. During this time they develop a network of friendships, which no doubt come into play when they begin their working lives. There are a number of men living in Barei who spend a part of each year in one of the urban centres, trading or engaged in work of some other kind. Some of these men have married a second wife in the urban area and are then bound to spend an equal amount of time with each wife and her children. A number of women have also spent some time living in an urban situation, up to 4 years in some cases.

TABLE 5 LENGTH OF URBAN RESIDENCE: RURAL SAMPLE

Years of residence	women		men		totals	
	no.	%	no.	%	no.	%
0	26	63.4	10	35.7	36	52.2
- 1	11	26.8	7	25.0	18	26.1
1 - 4	4	9.8	10	35.7	14	20.3
5 +	-	-	1	3.6	1	1.4
totals	41	100.0	28	100.0	69	100.0

Women who have spent less than one year living in an urban area have most likely been staying with a relative, a sister or aunt, perhaps to help during the time of birth of a baby. Those who have spent longer away from the village have usually been accompanying their husbands; they may have returned home to give birth or because urban life did not suit them, or because they were divorced.

In the rural areas, until recently, the only form of education available to the majority of people was that offered by the Qur'an schools. Nowadays both boys and girls have the opportunity to attend primary school in Guldo and the boys have the additional opportunity of the school in Daiya. No adults in the sample of the population had any formal education, and this was true for the whole population resident in the village at the time of fieldwork. However, it is quite common to find girls studying the Qur'an alongside their small brothers at one of the village's two classes. Barei is not a well-known centre for religious education, but there is a large school at Turra run by the family of the imam. Most of the children studying at the time of fieldwork were related to their teachers. All but one adult interviewed had attended Qur'an classes as children.

TABLE 6 EDUCATIONAL STATUS: RURAL SAMPLE

Educational Status	women		men		total	
	no.	%	no.	%	no.	%
no schooling	1	2.4	-	-	1	1.4
Qur'an school	40	97.6	28	100.0	68	98.6
Government school	-	-	-	-	-	-
totals	41	100.0	28	100.0	69	100.0

With few exceptions, the inhabitants of Barei, and the majority of those of nearby villages, are farmers, both men and women.

TABLE 7 OCCUPATIONS OF RURAL SAMPLE

Occupation	women		men	
	no.	%	no.	%
Housewife/farmer	34	83.0		
Farmer	7	17.0		
Farmer			15	53.6
<u>Shaykh</u> /farmer			2	7.5
<u>Feqi</u> /farmer			2	7.5
<u>Feqi</u> /Qur'an school teacher/ farmer/tailor			1	3.6
Farmer/ <u>imam</u> of mosque			1	3.6
Farmer/watchman of mosque			1	3.6
Farmer/cattle merchant			1	3.6
Farmer/merchant			1	3.6
Farmer/practitioner of country medicine			1	3.6
Merchant			1	3.6
Tailor/merchant			1	3.6
Tailor			1	3.6

Occupations are given in the table above as informants expressed them. Women thought of themselves first of all as housewives when they had a family, and then as farmers; elderly women, who were in most cases widows, felt that they could not be referred to as housewives.

They grow a variety of crops, e.g. millet, sorghum, small tomatoes (which are dried in the field), coriander, onions and ladies' fingers (also dried). The majority of women keep cattle, from 4 to 20 animals. All are taken to pasture early each morning after they have been milked and return around sunset to their corrals in the homesteads of their owners. The villagers have a rota system for cattle-herding and each family takes a day on which they have responsibility for the herd; a man, woman or teenage son or daughter may be the herdsman. Small calves do not go with their mothers to pasture but are kept in the village until they are able to travel the long distance to the pasture site, which may be several kilometres distant.

If a farmer cannot complete one of his tasks in time before the rains due to sickness or some other misfortune, he will arrange a towisa.¹

4.3 AN URBAN COMMUNITY - AZUMIYA NEIGHBOURHOOD, ZALINGIE TOWN

Originally Azumiya was a village established approximately 2km. (1 mile) outside Zalingie town. The neighbourhood still retains much of the style and structure of a village although it was moved by its founder to be adjacent to Zalingie, some 40 years ago; it remains at the edge of the town and is gradually expanding sideways as new inhabitants build. The decision to move nearer to Zalingie was taken mainly because of the difficulties experienced by the villagers during the rainy season, when they could not always reach the market if the Wadi Aribo was flowing.

1. See p.107, Chapter 3.

At the time of the move, (in the late 1930's and early 1940's) Azumiya consisted of some 75-80 households, mostly related to the founding family, which is today very large. The majority of the family members still live in Azumiya but some have gone to work elsewhere, notably in Khartoum and the Gezira towns. In 1979, when a survey of Azumiya was carried out for this research, there were 296 plots of land, of which 271 had inhabited houses. Twenty-five plots of land were either empty spaces or the houses were found to be empty or very dilapidated, their former owners having moved elsewhere. As the majority of houses are built of millet stalks, they very quickly fall into disrepair when unused, and the land reverts to its former condition, aided in most cases by the ubiquitous goats.

Zalingie, as an urban centre, has a mixed population of indigenous Darfur people, Arabs, Fellata from West Africa and traders from the Nile region, the Jellaba, some of whom migrated recently but many are descended from those who came up to two centuries ago. There is also an army garrison stationed in Darfur and many of the soldiers are lodging in Zalingie. Representatives of all these groups are found living in Azumiya, although it is undoubtedly a predominately Fūr neighbourhood. Azumiya is not far from the market (Hai el-sūq) and the centre of Zalingie and, more importantly for this study, is within easy reach of the hospital.

The majority of the residents of Azumiya have lived either in the neighbourhood or in another part of Zalingie for more than five years. A few have lived in another urban area before moving to Azumiya. Many people have lived nearly all their lives in the neighbourhood, some were

born there, others in another part of Zalingie. Those who have moved to Azumiya have tended to be born in other parts of Southern Darfur and Jebel Marra, though some Northern Darfurians have also migrated to Azumiya. A few individuals have migrated from Kordofan and the Nuba Mountains.

TABLE 8 PLACE OF BIRTH: URBAN SAMPLE

Place of birth	women		men		totals	
	no.	%	no.	%	no.	%
Azumiya (or Zalingie)	14	29.2	15	32.6	29	30.9
Elsewhere	34	70.8	31	67.4	65	69.1
totals	48	100.0	46	100.0	94	100.0

4.3.1 Homesteads and houses

There has been some attempt at town planning in Zalingie and the homesteads in Azumiya are fairly regularly arranged along straight roads which intersect with others at right angles. All roads have been made wide enough to permit easy access by lorry or tractor or, as was quite often necessary during 1979, by the fire engine. (The fire engine was new at this time and its arrival was a source of delight to many children who started a series of house fires of almost epidemic proportions in Zalingie, in order to hear its bell, to see its flashing blue light and its cannon of water.) In most cases, each household consists of several small round cottages constructed of millet stalks with grass-thatched

roofs. Some have mud-plastered inner wall surfaces. When they are able to, people build the more substantial square cottage which has mud brick walls reinforced with small stones, and a similar thatched roof. As they become more affluent, people usually build one or two brick rooms with corrugated metal roofs and wooden doors and window shutters. These rooms are not interconnected, both have doors opening to the outside only. The majority of householders also build a small cottage for the kitchen. All have one or two shade roofs, where much of the daily life of the family takes place. Cooking is often done outside, except in winter, as well as most of the other preparations for meals. Guests are entertained under the shade roof, especially in the early evening. It seems fairly common in Azumiya for the married couple, especially those under middle age, to occupy one of the cottages with their very small children but older children have cottages of their own. The small kitchen is rarely used by the woman nowadays apart from as a kitchen and store.

In Azumiya there is a greater degree of segregation of the sexes than in Barei and other mountain communities, though not to the extent found in larger towns in northern Sudan. There is usually a single doorway to the homestead, but inside there is a screen shielding the area of female activities from view on initial entrance. The house of the husband/father is built nearest to the entrance. There may be two shade roofs inside an urban homestead, one for male and the other for female entertaining. The visitors here are not quite so likely to be related to the householders, although many are of the main family of the

neighbourhood. Azumiya householders, whether working in the market, a school or government office are likely to have a number of unrelated friends who visit them. Also, they may have more visitors than rural people so there is less likely to be an easy-going friendliness between a man and his friends and his wife, as there might be in a smaller community.

The ground of the homestead is bare and is brushed daily with a grass brush, patterns being made in the dust. Little is grown within the homestead but occasionally gourds grow wild and these are left until they attain a useful size for a drinking vessel or ladle before being cut and dried. During my stay in Zalingie the horticultural section of the Jebel Marra Project brought seedlings of flowers to sell and several Azumiya residents bought them. Within a few weeks they had transformed the drab interiors of their homesteads into colourful flower-beds, an example of the relative ease of cultivation in the area - the only essential being a good supply of water.

4.3.2 Cattle and other animals

In urban areas, the cattle are usually corralled at one side of the settlement but they are often kept in the pastures with the herdsman, especially if the distance is far. Goats are kept within the homestead at night and are rounded up by children, who may take them to pasture; they are sometimes left to graze where they wish within the area of the neighbourhood or nearby. Chickens have coops built of bricks to protect them from night prowlers and pigeons have thatched coops above the chickens. Horses tend to be tethered inside the homestead, donkeys may

be kept in a collective corral. Dogs, if kept, tend to be their own masters.

4.3.3 Water

In Zalingie there is a system of piped water, obtained from deep bore-holes in the wadi bed, from which it is pumped up to large water tanks where purification by sedimentation takes place. There are a number of lockable outlets in the town which are manned twice a day and from which water may be collected by the householders in person, at the rate of $\frac{1}{2}$ piastre (approximately = $\frac{1}{4}$ p.) per 4 gallon can. Otherwise, water-carriers with their donkeys, which carry large skin water bags, deliver water to the houses of their customers, at the rate of $1\frac{1}{2}$ piastres per can. A family would have at least one large water container and this would be filled twice a day, taking 3 or 4 cans.

During the period of fieldwork, water was always available each day although sometimes, towards the end of the dry season, the length of time of flow was restricted, especially if the diesel fuel supply was low. The hospital has an almost continuous supply of water, as do one or two houses in the town.

The large water containers kept in every house, if properly maintained, cleaned regularly and placed where there is a passage of air, will keep water cool and clean for drinking. They are made of fired clay and are semi-porous and thus, cool the contained water by the process of evaporation.

4.3.4 Sanitation

In the urban area it is more common to have some kind of sanitary facility within the homestead, although by no means all people have made such arrangements yet. In Azumiya the pit latrine is probably the most widely used facility, but quite a number of householders who have the more modern brick-built houses, have also built a small roofed cubicle at the edge of their outer fence to house the bucket type of latrine. This cubicle has a raised platform with a central hole, under which is placed the bucket. The bucket is emptied via a flap-down door on the exterior surface of the wall by the 'night workers' of the public health office. These so-called 'night workers' are mainly Fūr men who daily empty the buckets into a tanker, which then disposes of the sewage material into a pit. A new pit is dug each day and public health officials are responsible for the proper and safe disposal of the sewage. The 'night workers' toil at their anti-social labours for about two hours each evening but they are paid very highly, by Sudanese standards, to compensate - £S30-50 per month. They also have the opportunity for other daytime work.

4.3.5 Other features of the neighbourhood

There are three small general shops in Azumiya and a flour mill. The Zalingie secondary and elementary schools for girls are situated near to the hospital and to the side of this is a small market where rush mats and locally made wooden beds are sold. There are two small mosques in the neighbourhood and the main Zalingie mosque is only two hundred

yards away, at the edge of the market. Zalingie market functions every weekday, and one or two stalls open on Fridays as well. Almost any type of goods can be found there - food, cloth, utensils, shoes, leather goods, metal ware, building materials, perfumes.

4.3.6 Some population data

There is no recent census data available concerning Zalingie or Azumiya. However, according to the Population and Housing Survey 1964/66, the percentage of Fūr among the total inhabitants of Zalingie was 37.5%, estimated by stratum (total population was estimated at 13,485). In this study, it was found, from a count of the households and by consultation with the chairman of the neighbourhood council, (a junior secondary school graduate) that the number of adults in Azumiya was 680-685, and the total population of the neighbourhood numbered some 1300 individuals (in 1979). The percentage of Fūr living in Azumiya is 70%-75% of the population, according to the chairman of the council, however, the percentage of Fūr in the survey sample was slightly lower than this - 68%.

Although this research is basically concerned with the Fūr and their system of medicine, they do not, of course, live in isolated communities in urban areas. Thus, some consideration has been given to non-Fūr individuals, both as healers and as recipients of traditional and modern medicine. As the responses of the non-Fūr men and women interviewed in Azumiya were so much in line with the responses of the Fūr inhabitants, these data were included with those relating to the Fūr, and analysed as material gained from the community as a whole.

The age and sex distribution of the sample of the adult urban population is shown below.

TABLE 9 AGE AND SEX DISTRIBUTION: URBAN SAMPLE

Age group* (years)	women		men		totals	
	no.	%	no.	%	no.	%
- 20	1	2.1	-	-	1	1.1
21 - 30	16	33.3	7	15.2	23	24.5
31 - 40	14	29.2	12	26.1	26	27.7
41 - 50	7	14.6	18	39.1	25	26.6
51 - 60	1	2.1	5	10.9	6	6.4
61 - 70	3	6.3	3	6.5	6	6.4
70 +	6	12.5	1	2.1	7	7.4
totals	48	100.0	46	100.0	94	100.0

(* age group is approximate in some cases)

Factors which influence the population profile include the absence of virtually all boys below the age of 20 years and of many young men below 30 years - they are either absent as muhajarīn or as migrant workers in others parts of Sudan - and women tend to be married to men about 10 years older than themselves - the marriage often occurs on the return of the young man from his wanderings or wage labour.

The married state is almost universal in the urban setting and no-one who was interviewed was divorced at the time, although a few

men and women had been divorced and had remarried. The two single people encountered in the survey, one man and woman, were a soldier and a young woman of 20 years still attending school, but who had her own house on land next door to her parents' home.

TABLE 10 MARITAL STATUS: URBAN SAMPLE

Marital status	women		men		totals	
	no.	%	no.	%	no.	%
single	2	4.2	1	2.2	3	3.2
married	38	79.2	44	95.6	82	87.2
divorced	-	-	-	-	-	-
widowed	8	16.6	1	2.2	9	9.6
totals	48	100.0	46	100.0	94	100.0

Few men in Azumiya are polygynous nowadays, less than 10 according to the chairman of the neighbourhood council. Most of the polygynous men had one wife in Azumiya and the other lived in his home village; this was the case with some traders. Two of the informants had both wives living in Azumiya, and in one case, in the same homestead. As one might expect, the number of widowed women exceeds that of widowed men. Although no widowed men appear in the survey sample of the population, they nevertheless did exist in Azumiya; two were encountered during fieldwork - one an elderly man and the other a hospital employee whose wife had died during childbirth.

Azumiya is a fairly well settled community, with only a small peripheral changing population. The great majority of the inhabitants

interviewed in the population sample had lived for more than 5 years in the neighbourhood. Many men had also travelled to other towns in Darfur, where they had either worked or attended Qur'an school as boys and young adults.

TABLE 11 LENGTH OF URBAN RESIDENCE: URBAN SAMPLE

Years of residence	women		men		totals	
	no.	%	no.	%	no.	%
0	-	-	-	-	-	-
-1	-	-	1	2.2	1	1.1
1 - 4	3	6.3	1	2.2	4	4.2
5+	45	93.7	44	95.6	89	94.7
totals	48	100.0	46	100.0	94	100.0

Few of the adult population at present living in the neighbourhood had attended secondary school, either in Zalingie or elsewhere, but a number of girls and boys nowadays attend school in Nyala and el-Fasher. Despite the fact that the first primary school for girls was started in Zalingie in 1946, relatively few women in Azumiya have received even primary education and only in the last 10 years have any girls completed senior secondary education. These few girls have usually then gone on to become teachers themselves. The great majority of the women have had no education at all, which is in contrast to rural women.

TABLE 12 EDUCATIONAL STATUS BY AGE GROUP: URBAN WOMEN

Educational status	-30		Age groups* (years)		51+		totals	
	no.	%	no.	%	no.	%	no.	%
no schooling	8	47.1	16	76.2	9	90.0	33	68.8
Qur'an school	3	17.6	1	4.8	1	10.0	5	10.4
Government school	6	35.3	4	19.0	-	-	10	20.8
totals	17	100.0	21	100.0	10	100.0	48	100.0

TABLE 13 FORMAL EDUCATIONAL STATUS BY AGE GROUP: URBAN WOMEN

Educational status	-30		Age groups* (years)		51+		totals	
	no.	%	no.	%	no.	%	no.	%
Primary	5	83.3	4	100.0	-	-	9	90.0
Junior secondary	1	16.7	-	-	-	-	1	10.0
Senior secondary	-	-	-	-	-	-	-	-
Adult education	-	-	-	-	-	-	-	-
totals	6	100.0	4	100.0	-	-	10	100.0

* age group is approximate in some cases

There are girls' primary and junior secondary schools built within the area of Azumiya but they serve other neighbourhoods as well as Azumiya. There is also a kindergarten recently started within the neighbourhood.

TABLE 14 EDUCATIONAL STATUS BY AGE GROUP: URBAN MEN

Educational status	-30		Age groups* (years)				totals	
	no.	%	no.	%	no.	%	no.	%
No schooling	-	-	1	3.3	1	11.1	2	4.3
Qur'an school	2	28.6	12	40.0	6	66.7	20	43.5
Government school	5	71.4	17	56.7	2	22.2	24	52.2
totals	7	100.0	34	100.0	9	100.0	46	100.0

TABLE 15 FORMAL EDUCATIONAL STATUS BY AGE GROUP: URBAN MEN

Educational status	-30		Age groups* (years)				totals	
	no.	%	no.	%	no.	%	no.	%
Primary	-	-	12	70.6	2	100.0	14	58.3
Junior secondary	1	20.0	4	23.5	-	-	5	20.8
Senior secondary	2	40.0	-	-	-	-	2	8.4
Adult education	2	40.0	1	5.9	-	-	3	12.5
totals	5	100.0	17	100.0	2	100.0	24	100.0

* age group is approximate in some cases

At the time of fieldwork there had been 4 male university graduates from Azumiya and several students were to graduate that year (1979) or the next. Most of them were encountered in Khartoum. The small

number of men shown to be attending adult education classes were in fact taking part in classes similar to those of an adult literacy campaign and were enthusiastic about this exercise. The two men who claimed to have had no education whatsoever, are immigrants coming from other ethnic groups - Masalīt and Halba Arab.

Two of the fegis resident in Azumiya run Qur'an schools; both are well known and respected in the region as a whole. One was asked by parents to come to the neighbourhood in order to start a school as there were too many children for the existing facilities. Many of the children attending this Qur'an school also attend formal education establishments in Zalingie. The other school is distinguished by the fact that one of its pupils has twice gained the highest marks in the provincial examinations for Quranic education. These two schools are perhaps somewhat unusual in that many of the pupils come from the surrounding households and they are also attending formal schools. Both girls and boys attend the Qur'an schools. One of the distinctive sounds in Azumiya in the early morning and around sunset is the chanting by the pupils of their portions of the Qur'an.

The majority of Fūr in Azumiya are farmers, each tending his or her own plot of land with the help of children and the spouse when need arises. Many of them also keep a few cattle for milk. These are taken daily by a herdsman, to pasture outside the neighbourhood. Women are also housewives and mothers and cope with house, children and farm, at least during the first 10 years of marriage. After this time, they are most likely to spend the main part of their time on the farm while an older daughter takes care of the home and any small children not at school. By the time they

have reached the age of 7-8 years, most children are quite self-sufficient and able to provide for themselves; it is at this time that young boys may begin to travel as muhajarīn and that young girls are given custody of the smaller siblings.

TABLE 16 OCCUPATIONS OF URBAN SAMPLE

Occupation	women		men	
	no.	%	no.	%
Housewife	10	20.8		
Housewife/farmer	25	52.0		
Farmer	5	10.4		
Market trader	2	4.2		
Farmer/trader	1	2.1		
Merchant/housewife	1	2.1		
Nurse	1	2.1		
Council labourer	1	2.1		
Housewife/farmer/rope-midwife	1	2.1		
Student	1	2.1		
Farmer			8	17.4
Merchant			8	17.4
Policeman			4	8.8
Soldier			2	4.3
<u>Feqi</u> /farmer			3	6.5
Tailor/farmer			1	2.2
Nurse			3	6.5
Clerk			2	4.3
Driver			2	4.3
Jebel Marra Project Worker			3	6.5
Transport manager			2	4.3
Caretaker			2	4.3
Office watchman/ <u>feqi</u>			1	2.2
Watch repairer			1	2.2
Merchant/ <u>feqi</u>			1	2.2
Prison warder			1	2.2
Member of Sudan Socialist Union (former teacher)			1	2.2
Tea seller			1	2.2

There are several people living in Azumiya who are not farmers first and foremost. Some do not have any land to farm, others have a spouse who farms. Among the men are merchants and traders, government office workers and labourers, nurses and teachers. Women work as nurses, midwives and teachers.

4.4 SEASONAL AND DAILY ROUTINE OF FÜR FARMERS

The inhabitants of mountain villages generally live quite some distance from their farms, 6-8km. (4-5 miles) or more. Thus, they have approximately an hour's walk along often steep and stoney mountain paths, in each direction, in addition to any work they carry out on the farm. Women always walk in the mountain area, occasionally they ride small donkeys in the lowlands. Men quite often ride their large donkeys. Most people have a load of some kind to carry to the fields or back to the homestead at night. On the way to the fields women often carry large and heavy pots of water on their heads for cooking the mid-day meal for everyone working in the field. Foodstuffs also have to be taken. Mothers of small babies carry them on their backs; pregnant women continue to work as long as they are able. Everyone collects and carries back firewood on the return journey; men sometimes collect grass for animal food for the homestead.

Work on the terraced fields is strenuous. The ground is prepared between May and June, being cleared of all remnants of the previous year's crop and any small bushes and shrubs. Fires are lit in the evenings to

burn the rubbish and these flicker throughout the night on the hillsides. Hoeing takes place when ground clearance is completed and the seeds are selected from the previous crop. This also is the time of the year when the rainfed tomatoes must be planted, usually in nearby but separate fields. At this time of the year, the first shower of rain (known as sugār) normally falls and people begin their final preparations for sowing. After the sugār, the star Banzar appears in the eastern sky and brings with it the heavy rains which are needed for the planting and germination of the seeds. This is the busiest time of the farming year, for not only do the seeds of millet begin to sprout but so also do the weeds. The appearance of another star, Abu Wal, heralds more rain and then weeding begins in earnest. Each plot of millet is weeded three times before the harvest in September, in order to prevent the luxuriant growth of intruding vegetation.

The harvesting of millet takes place in September and October, and that of tomatoes from this time on into December. In terraces which are irrigated, on the lower slopes of the mountain, the onion, garlic and wheat crops are planted in November. The wheat is harvested in April/May, while the onions are gathered in May. The wheat is threshed after reaping, while millet can be stored on a drying frame, if necessary, and threshed when required throughout the season. The heads of millet are cut from the stalks, collected and then laid out on the ground to dry for a day before being arranged on the drying frame to complete the drying process. After about a month, they are usually ready to be threshed.

After threshing the chaff is removed from the grain by winnowing and then the grain is collected and put into sacks or hide containers and taken back to the homestead, where it is stored in the large household grain stores.

Crops are more varied on the lower slopes of the mountain, in places like Nyrtete, where a large market has grown up. Here and at Golo, there are large orchards along the banks of the wadis, where citrus fruits, mangoes and bananas grow. The heaviest crop of these fruits is also in the months following the rains. The slack season for the farmers is between January and April and it is at this time that house and fence repairs and re-thatching can be done; it is also the time of greater contact between relatives who live in different villages. During these months women make pots for the coming year.

During the time of clearing and sowing, and again during the weeding, if a farmer has not been able to complete his or her work due to illness or business which necessitated travel and does not have enough household labour to call upon, he or she may decide to hold a towisa. For this, food and usually beer are offered for a day's, or part of a day's work in the fields. This is an enjoyable task and people sing and talk as they are working. Kinfolk, friends and neighbours join in; some may come from a distance. The event has a party atmosphere and is always regarded as being a happening to which it is well worth walking some distance in order to participate.

In the lowland areas, the farms are usually much nearer to the places of habitation. The seasonal variation is not very different from

that of the mountains, but there is a greater emphasis on irrigated cash crops, especially onions. However, there are more non-farming men or part-time farmers in the urban area, as many are employed as office workers, labourers, mechanics, drivers and watchmen by the local council or are merchants, traders, teachers, nurses and craftsmen. Some of them plant cash-crops while others find that orchards or gardens of fruit trees are easier to manage along with their other employment. Thus, there are more women farmers than men, as the majority of wives of the employed men have their own farms and gardens.

The daily routine, thus, varies with the season's work, although it has certain basic features which do not change, especially for women. The women are often at work by dawn, grinding flour for the first meal, bringing the calves to their mothers, milking the cows, making tea and going to the well for the first pot of water. After their hot milk and tea, in the height of the busy farming season, people begin to prepare for the day's work. Before they depart for the farm, the women go to the well again to collect water and then, with the necessary food items, they begin their walk to the fields, having sent the cows off with the herdsman and given the smaller calves their food in the homestead.

In the fields, the people work until after mid-day, when they stop, perform their ablutions and pray. After this, they eat their main meal of asīda, prepared by one of the women. Work then continues until sundown, when they prepare to walk home. Women then must go to the well again for water for both cattle, who return to the wells to be watered, and humans. Women of a family divide the water-collecting and

cooking if they can; thus, one goes to grind flour and cook the evening meal while the other is at the well. The second meal is eaten about 8.00 or 8.30 pm and tea is made and then all retire for the night. Sometimes, if the evening is cool and pleasant, people may sit around the fire for a short time, chatting about the day's events and tomorrow's programme.

During the slack farming time, the first meal may be taken in the early part of the morning and the villagers may then work around their homesteads, or prepare to go to a market where they will meet friends and relatives. They may then eat their second meal with those they have visited or prepare it at home. If women remain in the village during the day, they usually meet to make pots or food covers.¹ Sisters or other fairly close relatives who live close by, gather in the house of one of them and talk and sing as they work. They then collect water and prepare the evening meal. Meal times are varied in the slack season, depending upon other occupations and visitors. In the evenings people tend to sit and talk around their fires for much longer periods of time, sometimes playing with the smaller children.

People who drink merisa engage in this custom from the morning till late afternoon, by which time they are quite intoxicated and fall asleep. If there is any reason for merry-making, such as a marriage or circumcision party, drinking goes on into the night, accompanied by much dancing, drumming and singing. People generally do not engage

1. Food covers are made of dried grasses died with natural dyes usually in the villages but sometimes from imported dyes. Certain villages, such as Menawashi between el-Fasher and Nyala are famous for their food covers, made in bright colours, with artistic patterns - they are always an attraction to foreign visitors.

in drinking until later in the day when there is much work to be done on the farms, unless they are taking part in a work party. Although it is not very obvious, there is much drinking of merīsa on market days. Certain women are known to brew the beer and to be willing to sell it. Men and women go to the house of one who brews and drink in privacy, separately or together, depending on their kinship ties. The merīsa houses tend to have an exclusive clientèle. Not all Fūr drink merīsa; particularly, those of the main religious families do not.

As can be seen, the life of a Fūr farmer is not easy. This is especially true of the women who have the extra burden of childbearing and rearing, of the household tasks of drawing water and preparing food, and of looking after the cattle. Not all women brew merīsa, but for those who do, this is another laborious and time-consuming activity. However, the hardest work, in the months of May to December, is contrasted with the months of January to April when there is less stress and anxiety about the crops and time can be taken to relax a little. At this time, when household activities allow, the women make pots and people go to visit kinfolk, friends and neighbours, simply to talk and drink tea, occasionally to sing.

4.5 RELIGIOUS LIFE

The Fūr are Muslims and the religious land-marks in their lives are those of Islam - the naming ceremony of the baby, circumcision, marriage and death. The faith is centred upon the mosque found in each village, with its imam. The number of mosques actually depends upon the size of the

village or upon the number of factions. In Barei there are two mosques, since the disagreement about the succession of the last imam, when those who would not accept the son of the former, decided to build another mosque. In Azumiya there are two mosques in the neighbourhood due to its size rather than any splitting of the community.

In almost every Fūr village there is a Qur'an school¹ where the children begin to learn the Qur'an, by recitation, from a text which they copy from the feqi and then commit to memory by repeated chanting. Both boys and girls attend the school, especially in the rural areas. After they reach the age of seven years and usually before they are ten years, the boys leave home and wander in twos and threes from one school to another. The girls attend only the school in their own village. The majority of boys attending a Qur'an school are not from that village, but are just spending some time with that feqi before passing on to another.

The young pupils of the feqi copy the portion to be learnt that day onto their wooden writing boards and sit around the fire in the early morning and at sunset and chant their texts. Each text may be different and each pupil chants at the top of his or her voice. This is one of the familiar sounds of village life.

In Darfur as a whole, the Tijanniya sufi tariqa or brotherhood is the most widespread. All the informants encountered in the mountain villages and in and around Żalingie, belong to this tariqa. In comparison with many others, the dhikr² of this brotherhood is a quiet and constrained

1. The Qur'an school and feqi are described in Chapter 7 and Appendix 2.

2. dhikr is the invocation of the names of God and repetition of words and formulae in His praise.

affair which takes place within the walls of the mosque and is just audible as a low, rhythmically murmured chanting.

The rituals which the Fūr used to carry out in order to bring rain and to make the land fertile, to grow crops in abundance, appear by this time to have all but disappeared in the area of fieldwork. However, there are now the Islamic prayers which are said at the time of sowing seed and for the rains to fall at the right time to enable the young plants to benefit (timing of planting of the seeds and rains must be carefully judged to make the best use of the water; if planted too soon they may die before the next rain falls).

The Islamic rituals surrounding the main points of the life cycle of Muslims are described in the following section. Islamic healing techniques are studied in greater length in Chapter 7.

4.6 LIFE CYCLE

As people who live close to the land and who keep their animals in fairly close proximity to their own living accommodation, the Fūr are knowledgeable about anatomy and certain aspects of physiology. They expressed quite clearly that they recognize the connection between sexual intercourse and pregnancy but tended to evade the question of conception or expressed ignorance about the matter.

Almost all Fūr boys, the majority of rural girls and some urban girls learn at least part of the Qur'an by heart during their formative years. Some continue and acquire greater knowledge; relatively few go on to study

at establishments of formal education where they would gain a deeper understanding of their faith. The references to creation and procreation of offspring occur many times in the Qur'an, (Suras XXXII:6-9 and XXII:5-7 are two examples) so that it is likely that even those with a very limited knowledge would have encountered these ideas at some stage, either from reading or in conversation with others. However, they may not be sufficiently articulate to express their ideas.

Among older people, men in particular, who have undertaken further religious study and have been able to discuss and argue with others, one finds ideas and beliefs concerning procreation which are based on verses in the Qur'an. The following narrative is not uncommon. The informant is a feqi.

'My belief is that an angel comes and takes the liquid from a man and holds it in his hand and asks God if it can be made into a living thing. If the answer is 'yes', he throws it into the woman's stomach. If God says 'no', he throws it away.

After 4 months the woman will feel the movement of the baby which means that the liquid has changed into a blood clot and from this has become flesh and bones. At this time the angel brings a book and writes in the book if the baby will be male or female, the name and the events of his or her lifetime.'

The feqi then acknowledged that this was the extent of his knowledge, but that there were others who would have greater knowledge. 'There is always one who knows more', he said.¹

1. However, this is unlikely to be the limit of this man's knowledge on the subject.

Pregnancy:

Pregnancy is a state to be proud of among Fūr women and should, ideally, follow soon after married life has begun; it is a matter of some concern if there is a delay. However, if an unmarried girl should become pregnant, her family will try to encourage a marriage with the father of her expected baby or with an older man who will then adopt the child as his own. There is a much more relaxed attitude towards male-female relationships among rural Fūr and other rural Darfurians than is found in other parts of Northern Sudan and even in the more urbanized communities of Zalingie. There is a wide range of standards of moral principles on this issue. Families were encountered during fieldwork whose daughters were brought up (in an urban area) strictly segregated from men, apart from kinsmen. These girls would have been sent away from their homes at the very least, if they had become pregnant and would not or could not marry the father of the child. Another family was encountered where a young girl, of about 12-14 years, was staying in her parental home with her baby of 8 months. She had, apparently, only recently agreed to marry the father of the child.

Throughout pregnancy most women continue with their household and farming activities. Some complain of first trimester discomforts and sickness, but only on questioning; in general women tend to carry on as normal for as long as possible. During pregnancy there are no food taboos and the pregnant woman tries to eat well and of the foods she prefers, whenever possible.

Contraception:

The practice of contraception is not unknown to Fūr women, nor is it regarded as being essentially wrong to practice but it seems to be uncommon. The majority of women (as well as men) look favourably upon large families. Many women have lost at least one baby or small child or have had a miscarriage. The high rate of infant mortality has already been mentioned.

Methods used to prevent conception involve certain roots, which are made into a pessary and inserted into the vagina, or a written amulet may be burnt on charcoal and the smoke inhaled, or the amulet may be worn by the woman. All of these methods may be used together. There is also the belief that if a mother is feeding one baby, she cannot conceive. Perhaps for this reason, infants are often breast-fed on demand beyond the time when they have been weaned.

Abortion:

Spontaneous abortion of a foetus is not an uncommon occurrence among Fūr women, and is often promoted by a fever such as in malaria. However, several women interviewed were convinced that the abortion had been caused by anti-malarial drugs they had been given as treatment for their fever. In the instances where drugs had not been given, but abortion had still occurred, it was considered to be 'God's will'.

Fūr women do have methods of inducing abortion of unwanted pregnancies by use of plant materials, e.g. pieces of the stem of the Dead Sea Apple (Calotropis procera, L.), are introduced into the vagina, or other roots may be packed into the form of a pessary and inserted. As

far as could be ascertained, there are no rituals attached to inducing abortion.

If a spontaneous abortion should occur, one custom which might be observed is that of taking a young goat kid or a sheep to an anthill, where the sister of the woman who has suffered the abortion, rubs a reddish powder (obtained from a certain brown-red stone) mixed with water onto the centre of the forehead of both the animal and her sister. The woman who has suffered the abortion then leads the animal seven times around the anthill and goes back to her own home. Her sister then takes the goat far away from the homestead and frees it, so that it will not return. This practice is undertaken with the goat kid if the abortion is believed to be due to the mother's side of the family, if from the father's side, then the sheep is used. Another precaution against abortion re-occurring is to acquire an amulet from a feqi for this express purpose, or to ask the feqi to perform Cazīma onto a cord which the woman can wear around her hips.

Birth:

Birth normally takes place in the house of the pregnant woman or in that of her mother, if it is the first birth. Either her own mother or another older woman may act as the midwife or she may make arrangements with the modern midwife. This is becoming increasingly common nowadays, especially in the urban areas, despite many women's preference for the upright position encouraged by the rope-midwife (squatting or kneeling, supported by a rope from the roof). Many men are in favour

of the modern medical midwife attending their wives, both in urban and rural areas. The modern medical midwife, whether attending the mother in her own home or in a modern medical unit, delivers the baby according to the usual modern medical practice, with sterile instruments and with the mother lying on a bed.

Twin births are not common among the Fūr but if they occur they are welcomed, whether boys or girls. It seems that there are no special beliefs concerning the relationships between twins, it is said to be like that between any other siblings. If a handicapped baby is born and survives, it is cared for and taken to all types of practitioner in the hope of finding a cure somewhere. Only one severely physically and mentally handicapped child was encountered during fieldwork and he was well fed and cared for and integrated into the life of the family.

Babyhood and childhood:

The baby is with its mother in the homestead for at least the first seven days of life, and for 40 days if this is possible. After this time the mother will take the baby with her when she goes to the fields and to the market, held onto her back with a wrapper. She feeds the baby on demand. When the mother has to be taking part in farming activities, her younger sister or another young girl will look after the baby while she works. Until they reach the age of about three years, the child is rarely out of its mother's sight or hearing, unless with the child-minder. Once they are able to play with other children, they are more or less left to their own devices, in the charge of their older siblings or relatives.

Children are rarely restrained or cautioned about such dangers as the fire, cooking pots and hot water; they learn by experience. However, they do often receive a sharp smack if they repeatedly intrude into their mother's working space while she is preparing food. Resultant crying is usually soothed by a female relative or visitor but at times, the child may be gently ridiculed before soothing and sympathy are offered.

From babyhood to the age of seven years, children play freely, sometimes accompanying their mothers to the farm or the market; otherwise they are cared for by any suitable person, carried around on the back of the baby minder. The fact that from a very young age they are in the care of someone other than their mother, may mean that there is some inhibition to the development of strong attachment to any one individual, a feature which is reinforced in boys at the age of seven years when they begin their lives as muhajarīn. Small children are also quite often fostered by a female relative, especially the father's sister, but sometimes by the maternal grandmother, if there are no young children left at home or if the father's sister is childless.

Young children, particularly girls, are often left at home to look after the smaller children and they carry out most of the normal household tasks as well. They cook, draw water and carry it to the house, prepare the grain and grind it to flour. Under such circumstances one should not be surprized to find that the children suffer burns occasionally.

Circumcision:

Boys are usually circumcised at about the age of seven to eight years nowadays, although Beaton reports that it used to be performed at the

age of 14 years, (Beaton, 1948:16). Two brothers who are fairly near in age usually share the same ceremony. In urban areas and many rural areas nowadays, the operation is performed by a medical assistant or male nurse who uses a local anaesthetic and sterile instruments; it is less commonly done by laymen nowadays, although there are some healers who have specialized in the operation. Rarely, some infection at the site of operation may occur or (less likely) actual physical damage may ensue due to injudicious cutting.

According to informants, the practice of circumcising girls was almost unknown among the Fūr, except in urban areas, until a decade ago. However, it is mentioned by al-Tunisi (1854:97) and apparently the Emir Abd el-Hamid had tried to bring the custom to be practised in Darfur in the 1930's, but had been persuaded against this by the health authorities.¹ The operation is now usually performed by a modern medical midwife, using sterile instruments and anaesthetic, and should entail clitoridectomy only. However, due to the anaesthesia, and perhaps also due to overzealous urging by the older generation, more tissue may be excised than if the child was struggling in pain. Two young girls were interviewed a few hours after their circumcision operations; both were resting in bed but in good spirits and talking with their friends. Neither complained of pain and no ill effects were detectable, although the operation sites were not examined and the extent was, thus, unknown.

1. Personal communication with the late Sayid Usman Muhammed Kheir, Medical Assistant in Zalingie at the time (1930's).

Among more educated urban families, several young women were interviewed who had had the pharaonic type of circumcision. This had been carried out, no doubt, due partly at least to the belief that it is preferable to have the pharaonic type of operation, from the religious point of view,¹ but also possibly because it brings Fūr practices more into line with those of the rest of the Northern Sudan.

Although circumcision does not make men out of boys, a boy cannot really become a man if he is uncircumcised. However, both children are treated as if they are participants in a marriage; the jirtig, bridal ornament of red thread is put on the wrist, new clothes are given, perhaps to indicate that they are ready for marriage when the time comes, for here the symbolism ends. After circumcision, they are returned to childhood daily life. Circumcision is performed before a girl begins to menstruate, but menstruation itself does not appear to be of very great significance. It would appear that there is no ritual regarding the first or subsequent menstrual periods, although ladies' fingers (okra) is not eaten by married or unmarried women at the time of menstruation. My informants could or would give no reason for this, and it is not an absolute taboo.

1. In a paper on 'Psycho-social aspects of female circumcision' Dr Taha Baasher has pointed out that the oft-quoted saying of the Prophet Muhammed to the traditional practitioner, advising reduction but not destruction, was unreliable and unauthenticated. He also notes that the Mufti of Sudan clearly stated (in 1946) that obligation is not implied in statements by Muslim theologians who advocate the 'embellishment' as being 'preferable' or 'commendable', (Baasher 1979:6-7).

Old age:

Among the Fūr and in Darfur generally, in rural areas, people tend to live long lives. Many informants could remember Sultan Ali Dinar and his death in 1916 (about 64 years previously), and they had been adults at that time. This was the guide as to their age, as the majority of people do not know how old they are. Some informants had been married at the time of the death of Ali Dinar, others had had children by this time and a few had been grandparents. A few people could remember the uprisings at the time of the Mahdist state and this came to an end in 1898. Several people, by my own estimation, must have been well over 100 years and they were relatively active, though having some troubles with their sight. The 80 year olds in the mountain villages were still doing a little cultivating and growing some millet, and were fairly independent.

The elderly may live in their own separate homesteads but usually a married daughter, or perhaps a brother's or sister's daughter will have remained living in the homestead with her own family or be living next door or very close by. Certainly, the elderly are included in the extended family of a near relative in most cases. If for some reason an elderly person were alone, a neighbour would take on some responsibility according to informants. However, this situation is so unlikely to happen, it is hardly worth mentioning; there is always a relative who can come to live with or nearby the elderly, if the old person insists on remaining in his or her own home.

The elderly person, if able, looks after his or her farm, collects wood for the fire and keeps the homestead tidy. Old women go to the well

to draw water if they can; those encountered were very independent.

Elderly men whose sons may have taken over their farms, often meet in groups, especially on market days, and hold lengthy discussions about local happenings and current market prices. When at home or visiting a relative or friend, their talk often turns to points of discussion in religious matters. Elderly women do meet together at times but they are more likely to be involved in multi-generational groupings at home, in the kitchen or while carrying on with some household activity. Elderly people are always involved in some way in the upbringing of their grandchildren and they spend a great deal of time with them. They have an important role to play in the life of the family in Darfur.

Old people in Darfur and among the Fūr in particular, are certainly made to feel wanted in the family and in the community. They are respected and revered, and their advice is often sought by younger adults. In the case of traditional healers, their practical skills and knowledge gained over the decades, form a considerable reservoir on which to draw in times of need.

4.7 DIET

The staple diet of the majority of Fūr, in the rural and urban areas, is the porridge-like nung, or asīda, made from millet flour. This is usually taken with a hot spicy gravy or sauce made of onions, dried peppers, ladies' fingers (okra), tomatoes, spices and meat, if available.

Small amounts of meat are made to go a long way and only a thin strip may be used for each sauce. A piece of meat is expertly cut into thin strips by cutting around the edges - just a few ounces can be cut into many strips; it is then hung on a line inside the house for several days to dry, and can be pounded with the dried vegetables. The powdered foods are boiled, with seasonings, until the desired thickness and taste is obtained.

Most meat is cooked and eaten immediately the animal is slaughtered, except for the liver, lungs and stomach, which are eaten raw with onion and hot pepper mixed with lemon. The meat is cooked directly over the fire usually, as a barbeque. Pigeon, which is usually cooked for guests is also barbequed.

Apart from merīsa, the Fūr also enjoy karkadeh made like tea, from the dried calyces of Hibiscus sabdariffa and sweetened by the addition of large amounts of sugar; likewise lemon drinks are made with much sugar. Tea is boiled with sugar in the teapot and tends to be rather strong and very sweet.

Oranges, melons and mangoes, grown on the lower slopes of the mountain and along the wadi banks, are eaten in these areas, but they do not often get up to the higher markets as their main destination is one of the bigger markets such as Nyrtete, Zalingie, Kas, Nyala or el-Fasher.

The inhabitants of Azumiya have the advantage over the mountain dwellers of living near to a daily market and, the majority of them, also have a little more money with which to purchase a slightly more varied array of foodstuffs. Fresh vegetables may be purchased all the year round. Also there are a variety of other, imported foods, as well as dairy products brought for sale by the Baggara women and honey (a much prized delicacy) from the south of the district. From time to time most families in Azumiya do have a variation in their diet from the normal porridge, but it is still the main dish at least once a day; quite often fruit is eaten after the main part of the meal.

4.8 CUSTOMS RELATED TO MAJOR EVENTS IN FÜR LIFE

From historical accounts¹ it would appear that at one time there were a number of ceremonial customs performed in Darfur which are believed to have been rituals associated with divine kingship.² The accession ceremony of the new sultan, the 'first sowing' of the millet seed and the 'covering of the drums' each year, are examples of customs which seem to have died out now.

1. Accounts of Browne (1799), al Tunisi (1854), Felkin (1885) and Nachtigal (1971).

2. See Chapter 2.

These major public communal rituals stress Fūr identity and the boundaries of the society while, hopefully, ensuring its maintenance and well-being. Such rituals became obsolete along with divine kingship on the death of Sultan Ali Dinar in 1916. Nowadays the three types of large-scale rituals performed publicly are customs focussed on the individual - at times of circumcision, marriage and death - the major stages in the Fūr life cycle.

4.8.1 Customs related to circumcision

There is a wide variety of pre- and post-circumcision ceremonial, according to family wealth, area of residence (urban or rural) and, sometimes, whether it is for a girl or a boy. When there are several children of suitable age to be circumcised (between the ages of three and ten years), the parents make arrangements for the operations to be performed on boys and girls on the same day and they then share the same celebrations. The description which follows is of a moderately elaborate ceremony, others may be similar in form but less expensive.

The ceremony usually takes place in the school holidays, between the months of March/April and June. All the children to be circumcised are given new clothes and the girls receive gold bracelets and other jewellery. The party, usually a breakfast party, takes place on the day prior to the operations, under a specially constructed shade roof. This shade roof may be built in the roadway in the urban area, causing traffic to be diverted to the next street. This is where the men meet, talk and eat and where any entertainers may perform, women coming in to

watch or standing to one side. All those living in the street are invited. Women congregate within the homesteads where the children are to be circumcised, and many bring their cooking utensils in order to assist the mothers of the children.

The children are given sweets and presents and are dressed in their new clothes and then perfumed with powdered sandalwood and other aromatic substances. A red cord (Ar. jertig) is tied around the right wrist and the child is given a rosary (Ar. sibḥa) to protect against the evil eye and shayṭāns, and an amulet made by a feqi. Boys being prepared for circumcision in the rural areas used to go around to visit all their relatives on horseback and to receive presents, but recently this has been changed and a camel is now used. Some informants said that this change occurred because camels do not move as swiftly as horses if the boys should suddenly panic and try to flee. Girls do not make this excursion. Men and women closely related to those who will be circumcised, and often wearing clothes of the opposite sex, accompany the boys and move around the village or town neighbourhood dancing, singing and drumming, collecting all those who wish to join in. The women run in front of the boys, waving branches and rattles. This type of dance, moving from place to place, is called 'the gazelles flee' (F. firanga biya). As all gather at the home of the candidates for circumcision, and the day wears on, the dancing may change to that of the kossok (F.) for the young and the diddis (F.) for the older adults. In the kossok there is exchanging of clothing by close relatives of the children and the women let their hair down so that it hangs loosely, unplaited. This is in order to confuse any lurking evil spirits, according to informants.

Apparently there has been some considerable change in style of these dances over the last decade¹ and, whereas the dance used to be performed energetically, with somewhat erotic movements in close embrace with the partner, this is no longer the case. Non-Fūr officials and merchants have disapproved of such dancing and so the performance is nowadays relatively sober and the dancers stand side by side. This is borne out by a description of kossok movements by Roxane Carlisle (1973:793) in which she describes the couples ending up with simulated copulation. The performance she witnessed was in defiance of Muslim officials. During the present fieldwork two performances of kossok were witnessed. They were not erotic but certainly full of revelry and high spirits.

Nowadays in the urban areas, the operation of male circumcision is normally carried out by a male nurse or a medical assistant. People have become very aware that the healing is less problematic when sterile instruments are used. The practitioner of modern medicine also uses a local anaesthetic. A country medicine practitioner, who performs circumcisions occasionally, keeps a special knife for the purpose which he claims to sterilize before use. In rural areas, the operator may be a nurse or a practitioner of country medicine, or perhaps more likely, a general practitioner of medicine. Traditionally, for the operation of circumcision the boy, having first been sprayed with a thin mixture of millet flour and water,² sits on a large upturned wooden bowl (the receptacle for serving millet porridge).

Again traditionally, Fūr girls were not circumcised but nowadays in some urban families the operation is performed. In these families the operation used may be the drastic pharaonic form, or a form between this

1. According to two Fūr informants who are concerned to preserve their cultural heritage, which they see fading quite rapidly.

2. This will be referred to in Chapter 7.

and the minor clitoridectomy. The operation is often performed by a modern medical midwife, although she is supposed only to perform the minor type of operation. She uses an anaesthetic and clean instruments. A rope-midwife may also perform female circumcision and in this case the operation will be tending towards the drastic type. According to educated young urban women informants, a razor blade is the usual instrument of the rope-midwife, who operates on the screaming and struggling child. Consequently, tissue tends to be unevenly sliced away and complications of haemorrhage, urinary and pelvic infection may occur.¹

Following the operation of circumcision, the boys call out 'rejoice' (Ar. 'abshīr') snapping their fingers with arms raised, in order to show their happiness. The children are laid on beds,² sometimes in the same room, if they are young, and their female relatives cluster around them. The women - relatives, neighbours and friends - bring aromatic woods (Ar. bukhūr) and burn them over charcoal, and an aromatic paste (Ar. dilka) with which to rub the body, and give money known as kashif³ to those who have been circumcised. Men do not make this payment but instead may give a personal present to the child or donate a sheep, sugar or sweets to the celebration. The men may then depart after the breakfast, unless there is merīsa to drink.

The traditional circumcision ritual of boys can be seen as having the three sections described by van Gennep (1960:11), as follows:

-
1. The works of Saadawi (1980) and Sanderson (1981) vividly describe female circumcision, which I did not witness.
 2. Depending on the type of operation, girls may remain recumbent for 1-4 weeks.
 3. Ar. kashif - relating to 'uncovering' or 'revealing'.

- i. separation - the boys ride camels
they are perfumed, wearing new clothes
distinguished by the red jertig
- ii. transition - the boys are taken to the room for the operation
accompanied only by their fathers
at this time, erotic, transvestite dancing is
taking place (in the past)
a time of disorder
- iii. incorporation - the boys come back to the assembled
celebrants of the ritual
everyone rejoices
women cluster around the boys
boys are given presents

Girls also have new clothes, wear the jertig and are given presents.

The children may be circumcised together and share the party, but theirs is a much less celebrated procedure than the boys' circumcision.

4.3.2 Respect and avoidance

Respect and avoidance should be practised by a new son-in-law and daughter-in-law towards their respective parents-in-law. Following the marriage a man should try to avoid his mother-in-law and his father-in-law. If he finds himself in a position to meet either of them, he should try to hide himself or to get as far away from the path as possible. If he wishes to speak with his in-laws, the man may first give them an amount of money to initiate proceedings. There is, apparently, no fixed amount and a small sum will suffice. Evidence of avoidance was, however, not observed in either rural or urban situations and it would appear that in recent years, the money payment is instituted in its place as a matter of course.

Following her marriage, a new wife should avoid meeting her husband's brothers and sisters as well as her parents-in-law. They may, however, pay money to her in order to speak.

A man should continue to be respectful towards his wife's parents and brothers, after paying the money, expressing his respect in his greetings and in the removal of his shoes before entering the house. While walking in the village or outside, men may greet senior men and certain senior women, such as their grandmothers and their sisters, by kneeling or adopting a posture of bending forward over one bent knee. Men sometimes greet their own mothers in this way, but usually only within the homestead. However, this is a dying custom in the villages and almost non-existent now in the urban areas.

4.8.3 Customs related to marriage

Girls have often had a relationship with a boy or a young man before they marry. Sometimes they marry this person, sometimes not. There are always secret, and not so secret, meetings on the way back from the farms during the planting season and at harvest time, when people carry on working till after dark and then walk home in the moonlight. Girls and boys are always flirting at such times. If a girl becomes pregnant, she may marry the father of her child or her parents may persuade her to marry an older man as a second wife. Some girls may try to induce an abortion with the help of a practitioner of traditional medicine, but this happens rarely. No case was encountered of punitive measures being taken against an unmarried girl who became pregnant.

Girls used to be married from the age of 10-12 years in Darfur but nowadays there is a tendency for them to be older - 14-18 years; some may be older than this, especially in the urban area and when the girls

have received secondary education. Young men have usually reached the age of 18-20 years before marrying, but some wait until they have completed many years in the Qur'an school before marrying.

In the mountain villages there is little ceremonial attached to marriage. Usually there is drumming, dancing and merry-making, with an abundance of merīsa, although as soon as the contract is signed, the husband may simply take his wife to their newly-built joint home, in the homestead of her parents.

If there is dancing, then the people gather around a nucleus of singers and a drummer and dance around the village or neighbourhood, gathering up all the neighbours. This dance is the firanga biya. When assembled in one place suitable for the celebrations, the young boys and girls dance together (the kossok) and the older men and women (the diddis). During the revelry a rifle is shot into the air, men snap their fingers, shouting 'rejoice' (abshīr) and women ululate. This goes on late into the night.

4.8.4 Customs of meeting and greeting

Fūr women in both rural and urban situations, greet senior men and women, and often their peers, by kneeling and may continue to adopt this posture for some time while they carry out their conversation. They may rest slightly against a stone or large rock as they crouch in this position, each with a large water pot on her head and a baby tied to her back. When walking, a woman will never cross the path of a man and always waits for him to pass on before she proceeds.

When a Fūr mother-in-law wants her son-in-law to enter her cottage, she must pay him an amount of money first and then perform a short ceremony in order to avoid the chance of the young man being hit by a jinn. The mother-in-law sprays her son-in-law with a mixture of water and flour and makes the ululating call that women make at feasts and ceremonials. She then takes him into the house barefoot, and places his hand onto the large water pot on the cooking pots and on the grainstore inside the house. The young man is then allowed to treat the house as his own, but always leaving his shoes outside and entering barefoot.

When visiting another house, a woman may hesitate at the gateway and then, if no-one is around, she walks into the house and goes to the women's area, calling a greeting as she does so. She then removes her shoes before entering the cottage or sitting down under the shade roof on the rush matting. If there is a man in the homestead, the woman may remove her shoes at the outside gateway and walk in barefoot, kneeling to greet the man on the way. This custom is not so common nowadays in the urban situation, but is still usual in the mountain villages.

Women, when they are attending the dressing station or dispensary, remove their shoes at the gateway and tend to approach rather hesitantly. Even when attending for subsequent consultations, they leave their shoes at the doorway of the dispensary or dressing station. On their way in, women kneel to greet men, who wait outside; women wait to be seen inside, sitting on a wooden bench or bed.

When visiting the hospital as patients, women and some men leave their shoes at the door to the clinic. They also leave them at the door of a

ward when visiting patients. On confrontation with a doctor, medical assistant or other person of significance within the hospital, both men and women wait shyly without speaking until first greeted. They never proffer information about their condition and rarely engage the eyes of the person they are consulting.

In the presence of a shaykh or feqi, both men and women adopt the stooping position and most then kneel while they greet the religious man. They then adopt a more relaxed position and sit to one side of their legs. Men and women cover their heads when in the presence of such a religious man.

The Fūr do not greet effusively, but do so in a rather restrained manner, hardly showing their pleasure at the meeting, even if it is after a great length of time. The daily greeting is 'afe la konga' (or jonga), 'have you slept well?' or 'afe la komunga' (or jomunga), 'have you rested after noon?'. This greeting is given to all. Those meeting relatives, friends and neighbours follow their greeting with enquiries about health or the family. The Fūr are always interested to know where one is going, too.

On introductions and meeting in the homestead, people shake hands, but this is not a vigorous western handshake but only a slight clasp of the hand, especially among women. When men meet after some time, there is a more prolonged hand shaking and hand holding, especially among young men. Women may greet, in the urban setting, as the Northern Sudanese women - by lightly touching the left shoulder of the other woman with their right hand and then lightly touching hands. Within their homes, urban women have adopted the more western greeting of Northern Sudanese

women, of touching both cheeks, similar to the French greeting but without kissing.

In all types of greeting, the Fūr avert their eyes as a sign of respect, except for the occasional glance. In a situation where it is impossible to shake hands, if one is eating for example or cooking, Fūr offer the back of the hand and wrist for the new-comer to touch. This is done throughout Northern Sudan and is particularly common among religious men, though not all do so. Those who do not normally shake hands with women, but feel they should show some sign of greeting,¹ also offer the back of the hand and wrist.

4.8.5 Customs related to death, mourning and burial

In an urban area, when an individual dies there is immediately a loud wailing cry from the close female relatives and this brings those who live nearby, to the house.² As soon as possible after death, the body is washed according to the requirements of the greater Islamic ablution (ghusl) and perfumed by one or two close relatives of the same sex, and all orifices are closed with perfumed cotton wool (or other like substance). The body is then wrapped in a seamless white cloth and placed on a light locally made wooden bed, on which it is then carried to the graveyard. Burial takes place either on the day of death or the following morning.

1. As to a female anthropologist.

2. No Fūr deaths were witnessed during fieldwork, but three mournings (one of a Fūr) were attended. These were all of men who had lived in the urban areas and, according to Fūr informants, the Fūr do not have any different customs from those I witnessed. Rural customs are, perhaps, a little more sombre. Women do not attend burials, thus it would have been wrong to have attempted to do so.

During this time, the relatives come to the house to comfort and be with the spouse who is widowed and the sons and daughters of the dead person. At sunset the men pray together, standing in rows shoulder to shoulder, with the senior as prayer leader. After this they are given tea and spend some time with the mourners, depending on the closeness of the relationship. The men's part in the mourning seems to be fairly constant in rural and urban area, but the women's role in mourning in urban areas is more elaborate. The mourning and condolence customs of urban women involve much weeping and wailing as each new mourner comes into the room of the widow or the daughters of a deceased woman. Each woman comes up to the bereaved, who is seated on the ground dressed in a white tōb, and touches her on the shoulder and repeats the first sūra of the Qur'an, (el-fatiḥa). In such circumstances women weep for hours as each new mourner arrives to show her sympathy. Tears flow liberally as each new offerer of condolences arrives, but after some minutes she will be talking to another relative or friend with dry eyes. As each succeeding band of mourners arrives, the women burst into tears and wailing. The bereaved become increasingly wan and langorous as their original grief is continually emphasized by the emotionally traumatizing effect of being wept over and being among lamenting women for hours.

A woman who is bereaved remains in the room, or cottage, which she and her husband occupied, for 40 days (only leaving it for the necessities of life). She should then remain within the homestead for four months and ten days, (Qur'an 2:234). This is a feature of any Islamic mourning and is designed to ascertain the paternity of a child the widow might be carrying, although very old women also try to keep the period of

mourning. If circumstances do not allow such a period of mourning, as happens in some rural areas, the woman will try to observe the customary period of withdrawal from ordinary life. If her pregnancy is known, then it is optional for her to keep the mourning period.

Within the homestead of a bereaved family, there is much going on, for the mourners must be given food and tea, and the neighbours come in to cook. At the end of the 40 days mourning period, there is another meeting of the mourners and all eat together again. A collection may be made in order to buy a sheep to be slaughtered for this occasion. This custom is known as the karāma (Ar.), the token of esteem or honour for the dead person, and all who can should attend such a ceremonial meal.

The actual burial of a dead person is carried out by male relatives, who carry the bier to the graveyard, where the grave has been dug. Prayers are led by the imam as the body is lowered into the grave and then each mourner throws in some earth and the grave-diggers close the grave.

In Zalingie and Azumiya the grave is dug in a way that is similar to that of other parts of Sudan, i.e. a hole is dug which is much bigger than required for the body, about 2 m. deep, a deeper cavity is then dug in the floor of the first, measuring the length of the body a metre in depth, and the width of a man's hand-span. In Sudan the long axis of the grave runs approximately north-south, so that the body, lying on its right side with head to the south, faces Mecca. A small pillow of earth is made for the head and the limbs are extended and the body is placed into the narrow chamber. The opening is then closed with bricks

and the outer chamber is filled in with earth. In the mountain villages of Jebel Marra a slightly different grave is dug; the second chamber is dug into the east wall of the main chamber for the body, which is then placed so as to face Mecca. The recess is then closed with mud bricks and the main chamber filled in. The position may be marked by a stone placed on top of the grave.¹

4.9 SUMMARY

In this chapter, the two communities chosen for detailed study - Barei and Azumiya - have been portrayed as settings in which the rural and urban medical systems may be placed. Everyday life within the homestead and on the farm has been described, along with seasonal occurrences. Religious life in the community has been introduced here, but is detailed in Chapter 7 and Appendix 2, when the life-style and work of the feqi are analysed in greater detail. Some of the customs related to life events have been depicted for, although they are not daily occurrences, they form important focuses of ritual which 'oil the wheels' of community life. These occasional steps outside the everyday struggle for survival, are vital in the maintenance of the 'spirit' of the community.

1. The graves of the sultans at Turra have been built in a similar way, but they now have headstones and are marked by a very low edging. There is one strange feature about some of the sultans' and also some feqis' graves - they are much longer than any person is known to be, from 3.5m. (11 ft.) to over 9m. (30 ft.) long. The length of a grave is a sign of greatness and is a feature of the graves of many feqis. There is a story, however, that one of the sultans, Abd el-Gasim, swore to fight his brother even in death and so his grave lengthens as he tries to reach him. Knowing this threat, the graves were separated by crossed swords and a Qur'an buried between them. Abd el-Gasim's grave is over 9m. (30 ft.) in length.

This chapter concludes Part I of the thesis, which has provided a general background to Fūr life. The following three chapters form Part II, in which the intention is to concentrate on sickness and healing.

Sickness among the Fūr is generally conceptualized in terms of its cause. As will be seen in Chapter 5, there are a great variety of factors which are believed to cause sickness. An attempt has been made to assemble the various causes into categories which the Fūr might recognize, although they did not actually articulate a system of classification.

PART II

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Part I of the thesis comprized chapters outlining Fūr history and describing their ecological setting, against which background their social organization and everyday life have been portrayed. Part II now goes on to investigate sickness and its cause, the conduct of sickness and the practice of medicine.

The survey questionnaire is included in Part II before Chapter 5, as the majority of questions pertain to this and the following chapter. Only the English version is shown, but the questionnaire was administered in either Arabic or the Fūr language, whichever the informant preferred.

THE SURVEY QUESTIONNAIRE

Before embarking on the fieldwork for this thesis, an outline of a survey questionnaire was drawn up. This was divided into four sections: the first enquiring into biographical details of the informants - name, age, birthplace, occupation, education, marital status, length of urban living; the second section concerning peoples' beliefs about sickness in general and the action they would take if (in the hypothetical case) either they or their children became sick; the third section enquiring into beliefs and actions concerning a past episode of sickness suffered by the informants; the fourth section enquiring into beliefs and actions concerning the informant's present condition (if he or she happened to be sick at the time of interview).

Enquiries into the conduct of sickness - choice of practitioner, choice of medicine, place of treatment, payment for treatment, the caring group and visitors - posed few problems. Enquiries into beliefs about sickness cause were (not unexpectedly) more problematic.

While running a pilot study of open-ended questions in Zalingie and el-Fasher, it became evident that people did not generally mention certain categories of cause - those of mystical agents (other than the Deity), mischance or bad luck, nor were they referring to punishment (for unspecified conduct). All of these categories of cause had been mentioned many times in general discussions with practitioners of country medicine and also by lay people who were key informants. Thus, it was decided to add four questions at the end of the second section,

specifically about these categories. It was also decided to ascertain that all people do believe that God is the ultimate cause of sickness, whatever other intermediate cause might be conceived of as being the precipitating element in the episode of sickness.

Thus, at the end of the second section are specific enquiries into the informants beliefs about the likelihood of mischance (or bad luck), punishment for ritual or social conduct, jinns, the evil eye or sorcery being the cause of sickness. At the end of the third and fourth sections is one other structured question concerning mystical agents as cause of a personally experienced episode of sickness.

The survey questionnaire, then, was composed mainly of open-ended questions, with a few very specific structured questions concerning causative factors which are probably only used rarely by ordinary people to explain sickness. The rarity of their use, however, is not consistent with peoples' knowledge of possible mystical causes. A few other questions were structured as an aide memoire. For example they were helpful in aiding the informant to decide the length of a previous sickness - less than a week, two weeks, a month - or in the description of their state of incapacity - unable to move from the bed, able to get up, able to continue working. Without such a guide, informants were more likely to say 'I don't know'.

The survey was carried out in the urban neighbourhood some nine months after arriving in the field and in the rural situation two months later; pilot tests were held in el-Fasher and Zalingie before finalizing the form of the questionnaire and printing it. In both surveys the questions

were administered by the field assistants, whom I accompanied; in the village, the Fūr language was commonly used, in the urban neighbourhood, Arabic was usually preferred by the informants. All assistants were completely bi-lingual in Fūr and Arabic; the university-educated assistants were also fluent in English; the other two were fairly competent speakers of English. My own Arabic enabled everyday conversation and the understanding of others speaking; in the Fūr language I managed greetings and some polite conversation and an understanding of others in the field of questioning. Thus, I feel confident that the questions were understood by the informants and that their replies were correctly recorded.

Selection of informants for the survey questionnaire was carried out by a random choice of homestead numbers. Each homestead was shown on a sketch map of each settlement and given a number. Numbers were put into a bag and then 50 were drawn for women and 50 for men. In a few instances both husband and wife were selected from the same homestead. Very few individuals refused to co-operate and some of those who refused at first, after they had heard that their kinfolk or neighbours had responded, invited us back to complete their schedules. The number of men in the village is low because many men were away, working in the Gezira, Khartoum or in another town. Also, there are a number of polygynous men with wives in other villages or in the main towns of the region (merchants often have such an arrangement, with a town wife and a village wife) and there are a number of elderly widows. The 69 responses in the village (41 women and 28 men) form a 44.8% sample of the village population. The 94

responses in the urban neighbourhood (48 women and 46 men) form a 13.8% sample of the urban neighbourhood population.

Evaluation of the questionnaire:

The survey questionnaire proved to be fairly appropriate and was a useful tool in gaining indication of tendencies in belief, thought and practice. However, it could have been improved by further enquiry in two areas - the state of sickness and the ailments of children. Investigations into (i) Fūr thought and belief regarding the state of mind and body during the period of time when an individual is designated 'sick' and the changes resulting in sickness and its sequelae, and (ii) the cause, prevention and theory of treatment of children's ailments would have presented a fuller picture of sickness throughout the population. An enquiry into maternal emotions regarding sickness in childhood would have enabled the development of an understanding of the mother-child relationship which, with the additional data outlined above, would have given greater depth to the indigenous folk model of sickness and healing among the Fūr.

Questions regarding duration of past sickness, seriousness and incapacity experienced could have been omitted, as they are subjective and rely too much upon memory - often of events long past.

While planning the survey it was decided to interview 100 people (50 men and 50 women) in both survey areas. However, in the rural area the number of survey questionnaires completed was very low, particularly among the rural men. This resulted in certain

sub-categories in the tables which follow showing very few respondents.

While basing observance on participant observation, the anthropologist is always faced with the problem of representing the way of life, thought, belief and practice of his or her informants. A survey questionnaire was seen as a method of gaining a spread of the information available concerning the two communities studied. The results of the questionnaire should be seen as indicative of trends; they are not intended to be regarded as statistically valid.

THE SURVEY QUESTIONNAIRE

Section 1.

1. Community - rural village
urban neighbourhood
2. Name
3. Sex
4. Age
5. Marital status
6. Place of birth
7. Ethnic group
8. Occupation
9. Education - nil/Qur'an school/primary/secondary/further education.
10. Urban residence - 0/-1/1-4/5+ years

Section 2.

11. What do you usually do when you are sick?
12. How would you expect to be treated?
13. Suppose you did not get better, what would you do?
14. If your child is sick, what do you do?
15. What do you believe causes sickness?
16. Do you believe sickness is due to mischance or is accidental?
17. Do you believe sickness comes as a punishment from God for misconduct/wrongdoing?
18. Do you believe that sickness is due to God's will?
19. Can jinns, shaytāns (devils), the evil eye or sorcery cause sickness?

Section 3.

20. Have you ever been sick (or had any injuries)?
21. When?
22. What was wrong with you?
23. What caused it?
24. Were you able to get up and about/able to get up but remained in bed/
up but not carrying out normal activities/carrying out normal
activities?
25. Did you have any sort of treatment?
26. What treatment?
27. Who treated you?
28. Did you improve?
29. (if 'No') What did you do then?
30. For how long were you sick? - a day/2-6 days/1-2 weeks/
3-4 weeks/more than 4 weeks?
31. Why should this have happened to you?
32. Were you satisfied with the treatment you had?
33. Who looked after you?
34. Did people come to visit you when you were ill?
35. Who?
36. Did you go to the (practitioner of medicine) or did he/she come to you?
37. (if the latter) Who called him/her to treat you?
38. Was he/she paid for the treatment?
39. (if 'Yes') How?
40. How serious was your sickness/injury? trivial/moderate/very serious
41. Why did you consult that particular (practitioner)?

42. How did he/she decide what was wrong with you?
43. Do you think that jinns/shaytāns, the evil eye or sorcery could have caused your sickness/injury?

Section 4. Following Q.21 if the answer is 'now'.

44. What is wrong with you?
45. What caused it?
46. Are you able to get up and about/able to get up but prefer to stay in bed/up but not carrying out normal activities/carrying out normal activities?
47. Are you having any sort of treatment?
48. What treatment?
49. Who is treating you?
50. Are you improving?
51. (if 'no') What are you doing about this?
52. For how long have you been ill — a day/2-6days/1-2weeks/3-4 weeks/ more than 4 weeks?
53. Why should this have happened to you?
54. Are you satisfied with your treatment?
55. Who is looking after you?
56. Are people coming to visit you?
57. Who?
58. Did you go to the (practitioner of medicine) or did he/she come to you?
59. (if the latter) Who called him/her to treat you?
60. Was he/she paid for the treatment?

61. (if 'Yes') How?
62. How serious is your sickness/injury: trivial/moderate/very serious?
63. Why did you consult this particular (practitioner)?
64. How did he/she decide what was wrong with you?
65. Do you think that jinns/shaytāns, the evil eye or sorcery could have caused your sickness/injury?

Chapter 5

SICKNESS AMONG THE FÜR

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5.1 INTRODUCTION

Chapter 5 makes a brief excursion into 'health' as the Fūr explain it, before discussing 'sickness' at length. Fūr concepts of sickness centre on causation. Their ideas of cause are varied, ranging from God to environmental factors and, occasionally, to mystical agents.

Rural people tend to find their explanation for sickness within their relationship with nature, while urban dwellers also call upon another aspect of their life, the religious, which takes a more apparent form in the urban situation. Factors such as urban life, travel and formal education, or at least the mixing with travelled and educated individuals, it is argued, have been influential in shaping ideas and beliefs about sickness as social change has taken place.

5.2 SICKNESS

The healthy individual, according to Fūr informants, is active and goes about his or her normal daily routine without complaint, pain or infirmity. The eyes of a healthy person are bright and the skin is smooth and glowing. On the other hand, a sick person appears paler than normal and the skin has the appearance of being tight and drawn, without lustre. The eyes are said to be 'dull', in the sense that they lose their intensity of colour and also their 'inquisitiveness'. The speech of the individual slows down during an episode of sickness and there is a change in

temperature leaving the sufferer feeling cold. Along with these symptoms is an associated inactivity or apparent laziness. As one informant said, 'you can see the change when you know the person healthy'; an observation which indicates, perhaps, that sickness is regarded as something one can actually recognize by its outward symptomatology. This, then, is an indication that lesser degrees of discomfort and infirmity might not be thought of in terms of sickness.

Having witnessed the positions people adopt in order to till the ground (bent at the hips but with straight backs and legs), and the strenuous exercise, for women, which is entailed in drawing and carrying water, one could not imagine that the Fūr farmers escape unscathed and without quite severe aches and pains, at the very least. People never seem to complain of occupationally induced discomfort but, on closer questioning, it is apparent that they do suffer almost continuous aching of the back and neck, and knee and shoulder joint pain during the busiest times in the farming year. (See photograph 2, p.197.)

Another factor regarding sickness recognition is that people tend to wait a little while to see how a sickness will develop or if it will subside, especially if the sufferer still looks 'normal' and therefore also 'healthy' - as described above. Bound up with this attitude of 'wait and see' there is also the frequently voiced concept of fate (gisma).¹

When they feel that their state of health has deviated from the normal and that their functioning and behaviour are not as usual, the Fūr

1. gisma, or more correctly qisma (Ar.) - share or portion, fate.



2. POSITION ADOPTED FOR HOEING

may use a variety of ways of expressing their discomfort. They may make the general statement 'sor gi wey', which can be interpreted as 'I am ill' or, more literally, 'the body is paining me', or they may go on to elaborate with regard to symptoms and the area of discomfort or pain. Perhaps the most common complaints are those below:

<u>kirro</u>	- fever (also malaria)
<u>tabongwey</u>	- headache
<u>deyongwey</u>	- abdominal pain/disturbance
<u>lo dis</u>	- diarrhoea
<u>lamey</u>	- dysentery
<u>namu</u>	- cough, cold, chest trouble

The explanation of sickness episodes, perhaps not unexpectedly, often involves the naming of the site of the complaint and its possible cause or causes rather than an elaboration of symptoms and differential diagnoses. Although the Fūr are quite well acquainted with anatomy and the positions of body organs from their slaughtering and butchering of animals, they have only vague ideas of physiology. Thus, they turn to reasons of 'why' they should suffer and 'how' a condition came upon them. Such questions can be answered by the wide range of causal factors at their disposal, some of which are shown in Table 17 (p.202).

The following examples give some idea of the Fūr naming of diseases.

- (i) Diseases named after the part affected, such as 'head pain', tabongwey, 'stomach pain' deyongwey, and 'tooth pain' kagingwey.
- (ii) Diseases named after the cause, such as epilepsy which is believed to be due to being hit by a malicious spirit - sometimes called saytān or shaytān (devil); leprosy (kewa) is believed to be in the blood (kewa) and passed on in this way in the family; malaria (kirro) is regarded as the sickness of the 'green season' (i.e. the rains) - kirro is the colour 'green' in the Fūr language; um shabata and Cankabūt (skin diseases) are named after the spider believed to cause them by biting and leaving small red marks.

- (iii) Diseases named after the signs or sensations produced in the sufferer, coughs and colds, namu so called because of the mucous produced in these conditions, although there are many different types of namu according to a further differentiation of cause; cerebro-spinal meningitis tabung joldi vividly explains that the sufferer is experiencing a 'striking of the head'.
- (iv) Some diseases are named euphemistically, perhaps with the hope of placation, especially when they are usually or commonly fatal, as in the case of measles, known by a variety of names - abo kassimba, abo affa or just abo or uwo, all names for grandmother or grandfather or respected elderly person.

Sickness does not occupy an important place in Fūr topics of conversation, even when an individual is unwell. When sickness is discussed, the discourse could be expected to take the direction of 'how' and 'why' the condition arose. People do not, it seems, generally engage in philosophical conversation regarding the nature of sickness, and during fieldwork it was found sometimes to be difficult to draw lay informants into conversation concerning it. This, I felt, was not because they were unwilling to co-operate, but rather was due to the fact that they were unused to such discussion. Healers were found to be more forthcoming. Younger women were particularly reticent and often dissolved into nervous laughter when interviewed about sickness cause in particular although they responded easily during other aspects of the survey schedule; it may be that there is a belief among certain individuals that to talk of sickness might invoke it, but this was never mentioned. In fact the converse is more relevant - to talk about health, or to refer to the beauty of a child is believed to result in sickness or some other misfortune, usually due to the evil eye.

Structured questions proved to elicit more information when individuals needed help in initiating a response. Open-ended questions frequently brought forth the reply 'I don't know', which might have been genuine but could also have been used to deflect questions requiring thoughtful consideration or ones to which they did not wish to reply. Acquaintance with these same women outside the unusual situation of administration of the survey questionnaire leads me to believe that their knowledge is much greater than can be judged by their responses to questions regarding sickness. (On occasions when I was suffering what I considered to be fairly minor complaints, they came to visit and, when their advice was sought, displayed knowledge of a number of possible alternative diagnoses and treatments.)

Fūr women, in particular, go to great lengths to visit the sick, to comfort them and do any small service which may be requested of them. Men also visit the sick of course, though possibly not to the same extent. Since it is generally known that the major fatal epidemic diseases have now been controlled or eradicated, peoples' fears of contracting sickness have diminished, according to some fegi-informants, as well as to practitioners of modern medicine. During the early days of modern medicine in Darfur, the former medical assistant, the late Usman Muhammed Kheir, told of people denying the presence of smallpox or running away and hiding when he visited villages where the disease had broken out. He managed to detain some people and vaccinate them and also treated others. The survivors and those who were protected from the disease by prophylaxis became strong supporters of modern medicine.

When sick people have to be admitted to hospital, they do not like to be physically near to others who are sick. If the sick individual is able to leave his or her bed, he or she will move outside the ward with kin of the caring group and any visitors and find a suitable place to sit, preferably under a shade tree. If the sick individual is unconscious or too weak to display sentiments regarding proximity to sickness, the members of the caring group gather around the bed as a human screen, waiting for the first signs of recovery. Very often, when the sick person is very ill, someone remains at the bedside throughout night and day.¹ As the individual recovers, the number of kin forming the caring group decreases.

5.3 CAUSES OF SICKNESS

The following is a list of all causes of sickness given by informants in the survey of the two population samples, in response to the questions 'what do you believe causes sickness?'. The frequency of each type of cause is given as many informants gave several examples of cause.

1. Regulations regarding visitors to the sick are virtually non-existent in small rural hospitals.

TABLE 17 CAUSES OF SICKNESS CITED BY FÜR INFORMANTS

Causes of sickness	Frequency				Total
	Rural sample women	sample men	Urban sample women	sample men	
1. Causes associated with climatic conditions:					
heat/the sun	6	3	3	1	13
cold	-	-	-	1	1
dampness	-	1	-	-	1
wind	1	-	-	-	1
the weather/change in weather	1	-	1	-	2
dust	-	1	-	-	1
2. Causes associated with disease transmitting factors:					
mosquitoes	-	1	-	3	4
flies	-	1	5	2	8
insects	-	-	-	2	2
epidemics	-	-	-	1	1
<u>baktiriya</u> ¹	-	-	1	-	1
<u>jurthūm</u>	-	-	-	1	1
increased transportation bringing disease	-	-	-	1	1
3. Causes associated with mystical agents:					
God/will of God	1	7	16	17	41
fate	-	-	-	1	1
bad luck	-	-	-	1	1
<u>jinns</u>	1	-	-	-	1
evil eye	2	-	-	-	2
magic	1	-	-	-	1
sorcery	-	1	-	-	1

1. baktiriya (Ar.) and jurthūm (Ar), as well as mikrūb (Ar.) were used quite often by urban informants and were described as tiny animals too small to be seen with the eye alone.

Causes of sickness (contd.)	Frequency				Total
	Rural sample women	men	Urban sample women	men	
4. Causes associated with the individual, his habits and activities:					
poor/inadequate/ unsuitable diet	-	2	2	7	11
dirty/bad food	-	3	1	5	9
<u>merīsa</u> /alcohol	-	1	-	2	3
dirtiness/lack of hygiene	-	4	9	6	19
carelessness	-	-	-	4	4
poverty	-	-	-	1	1
weakness	-	-	-	2	2
exhaustion/fatigue/ hard work	7	7	-	3	17
mental and physical stress	-	-	1	-	1
<u>anīmiya</u> ¹	-	-	1	-	1
<u>dwillā</u> ²	1	-	-	-	1
5. Causes associated with punishment for certain conduct:					
a punishment for wrong- doing	-	-	1	-	1

At this moment I wish only to draw the reader's attention to a few points which this table indicates. First of all, the table demonstrates that rural people favour causes of sickness which reflect their closeness to nature and the arduous monotony of their subsistence; secondly it shows that it is only among the rural portion of the sample that mystical agents (other than God) featured as a cause of sickness. Thirdly, the

1. anīmiya - arabicised form of anaemia - weakness or thinness of the blood.

2. dwillā (F.) - translated as 'bile' or 'biliousness'.

table shows that urban people tend to favour causes of sickness which are associated with the individual and his activities and habits; factors concerned with hygiene and diet are prominent here. Fourthly, the major cause of sickness cited by urban informants is God or the will of God. The causes of sickness cited by urban people is perhaps an indication of the increasing complexity of life in the urban situation where new and different ideas are constantly being tested in a situation of formal learning and religious life, where subsistence is not such a problem.

During informal discussions with practitioners of country medicine and also with key lay informants, other causes were stressed, in addition to those already listed above. Perhaps the most outstanding feature of the collective beliefs of feqis, in particular, is their insistence on or resistance to the idea that sickness is due to some interference by mystical agents of one sort or another. On the one hand there are feqis who strongly deny that sickness can be due to anything but the will of God, although they do recognize the existence of jinns and other spirits - they are mentioned in the Qur'an - and that some feqis perform sorcery and black magic - but they do not believe that these things can cause sickness. On the other hand, some feqis describe 'other feqis' in 'other places' who can write a magical spell, rather like the religious amulet (hejab) worn by most people but obviously for malicious ends, which is then buried in the ground ready for the victim to walk over it. If the black magic spell can be buried in a graveyard and the intended victim walks over it, death will be assured; such a spell can

also cause fire to break out. Informants knew about such spells and black magic because they had been asked to reverse such sorcery. No-one could admit to performing such evil deeds themselves, a strictly anti-Islamic practice.

The other favoured causes of sickness among believers are the jinns and other spirits. Living in the house of a non-Muslim jinn or passing sites known for their previous association with spirits, such as disused mosques, graveyards, old trees and caves, are certain invitations for the said beings to make havoc.

One female informant mentioned the 'hot eye' (el-^cayn hār, Ar.) another version of the evil eye, 'the eye' or 'the look'. This frequently mentioned phenomenon in daily conversation, particularly by women, was hardly ever mentioned during the responses to the survey questionnaire. Many fegis said that they could give relief to people suffering from evil eye caused sickness. It should be mentioned here perhaps that many of the causes of sickness mentioned by informants can cause a variety of sicknesses. In other words, cause and sickness are not necessarily linked, except in the particular instance. Mystical causes are typical of this characteristic.

Fegis often pointed out instances where people could become sick due to their lack of performing the correct ablutions after urinating or having sexual relations. Also, 'playing' with another man's wife can cause serious sickness. A woman who has sexual relations with a man other than her husband, may have difficulties during labour. However, a woman having labour difficulties will not necessarily be charged with having

had sexual relations with another man. It is more a thing of conscience for the woman to decide for herself, if the possibility is there. A point worth noting, though, this cause of labour difficulties was only mentioned by men, women's ideas about the cause were usually concerned with fatigue and the heavy work they carried out on the farms; occasionally they mentioned the evil eye. A man can also become sick if he has sexual relations with a woman who is menstruating, or if he drinks merīsa made by a woman at the time of her monthly period - according to a number of men, mostly fegis.

An elderly Fūr man living in Khartoum, but who had lived nearly all his life in a small village, was convinced that sickness was related closely to the standard of living in towns. He felt that villages were generally healthier places now that the major epidemics had been controlled. He had seen much disease in Khartoum which he related entirely to town living.

A number of people had sickness specific causes to relate. Malaria, caused by the mosquito, occurs particularly where there are animals and humans. The mosquito sucks blood from the animals and then injects it into the human. The incompatibility of animal and human blood results in the fever. Bilharzia comes from contaminated water. Adults get it working in the irrigation channels in the Gezira and children can get it from playing and swimming in the seasonal rivers. Dysentery is transmitted by flies which bring dirt to food when they alight on it.

Chest conditions can be due to a number of factors, mainly environmental and already mentioned, but several informants spoke of the dusty conditions during the dry summer months before the rains and also of smoke of the Haraz tree (Acacia albida, L.), cotton fibres and other small particles. An enlarged spleen can also cause trouble by spreading up into the chest - the enlarged spleen itself being due to eating food which has been prepared a long time.

As if summing up, one relatively young practitioner of country medicine who worked with the Jebel Marra Project in Zalingie, remarked that sickness is due to a bad health service and lack of preventive measures.

Towards the end of the period of fieldwork a number of Fūr informants were individually asked to name the causes of certain general symptoms and a number of specific disease entities. They were then asked what type of sickness might be caused by a number of causative factors. The results are shown in the two following tables. The symptoms, disease entities and causative factors were those most commonly mentioned during the fieldwork by informants.

TABLE 18 FACTORS CAUSING SPECIFIC SICKNESSES

Fur	Sickness		Caused by
	Arabic (colloquial)	English	
<u>namu</u>	<u>nazla</u>	cold	the weather; the cold; bathing at sunset.
<u>julunga</u> <u>namu</u>	<u>kuḥḥa</u>	cough chest trouble	the wind; the weather; dust.
<u>kirro</u>	<u>humma</u>	fever	heat; hard work; bad food.
<u>kirro</u>	<u>mālāriya</u>	malaria	mosquitoes; change of season; the rains; the 'green season'
<u>lo dis</u>	<u>ishal</u>	diarrhoea	bad/old food; flies; hot red pepper (Ar. <u>shaṭṭa</u>)
<u>lamey</u>	<u>disintāriya</u>	dysentery/ diarrhoea	dirty food; bad meat; flies.
<u>tabungwey</u>	<u>waja ras</u>	headache	hard work in the sun; being hit by <u>jinns</u> ; the will of God.
<u>rong asar</u>	<u>bilharziya</u>	<u>Bilharzia</u> (schistosomiasis)	bathing in still/warm water.
(<u>namu</u>)/ <u>kogo</u>	<u>tī bī</u>	tuberculosis	undernourishment; smoking; from another with TB; from cows.
<u>abo</u>	<u>judari</u>	smallpox	dirtiness; carelessness about washing and hygiene.
<u>abo kisimba</u>	<u>hiṣba</u>	measles	it comes indiscriminately; it is from God.
<u>tabung</u> <u>joldi</u>	<u>siḥaiy</u>	cerebro-spinal meningitis	the hot weather
<u>kewa</u>	<u>baras/</u> <u>judham</u>	leprosy	one is born with it; it is in the blood; eating the meat of an ostrich after first refusing to do so.

TABLE 19 SICKNESSES CAUSED BY SPECIFIC FACTORS

Causative factor	Sickness
hard work, especially in the sun	joint pains; vomiting; fever
the weather, particularly cold weather	colds; cough; fever
the sun/hot weather	fever; headache; <u>tabong joldi/sihaiy</u> (possibly cerebro-spinal meningitis)
bad food/meat	<u>lo dis/diungwey</u> (diarrhoea/dysentery)
inadequate food/poor quality food	swelling of the stomach; <u>anīmiya</u> (thin blood/anaemia)
<u>shaṭṭa</u> (hot red pepper taken in plenty)	abdominal discomfort; <u>disentāriya</u> (possibly diarrhoea)
mikrubat (microbes) or <u>jurthūm</u> (a germ) entering the body	<u>titanūs</u> ; <u>kirro</u> ; <u>bilharzia/rong asar</u> ; <u>korsei-korsei</u> , (possibly tetanus; fever; bilharzia and abscess)
<u>jinns</u>	<u>ulūl</u> (madness/mental disturbance); <u>arīt</u> (possibly epilepsy); a change in the mind and behaviour
<u>nongi</u> (the evil eye)	sudden unconsciousness/deep sleep; itching of the skin; <u>lo dis</u> and <u>kolgiya</u> (diarrhoea and vomiting)
<u>tib</u> (sorcery)	<u>ulūl/junūn</u> (madness); loss of speech; 'tying' of the limbs (paralysis); impotence (<u>toyeng</u>) in men.

Mental disturbance and frank 'madness' are attributed to mystical agents (namely jinns). As will be seen from two short case studies, which are not atypical, the people suffering what they believed to be mystically caused sicknesses, had been suffering these complaints (or what they considered to be chronic symptoms of one complaint) for some considerable time.

Case 1 - a man of some 35 years living in the urban neighbourhood, where he had been resident for over five years. He had attended Qur'an school as a boy and was, at the time of interview, attending adult education classes. This man said that if he or his family were ever sick, then he would consult a modern medical practitioner although, if he did not progress satisfactorily, he would probably then consult a traditional healer. He was very uncertain as to what might cause sickness but believed that it could be both mystical and natural factors.

He, himself had been suffering some stomach troubles since 1973 (about 7 years), which he believed to be due to the evil eye or to sorcery. He related the history of these stomach troubles, which involved a burning sensation 'going up and down'. One evening, when he was walking home, he heard a woman's voice calling him by name and saying that she wanted to bear him a child. According to him, he had nothing to do with her but rushed home. Immediately his stomach began to trouble him.

He had consulted a doctor at first and then a root specialist and several feqis, as he said, 'to be sure of all possibilities'. He had been treated with tablets and a syrup by the doctor, roots by the root specialist and with miḥaya by the feqi, and was still suffering, on and off.

Case 2 - a woman of some 30 years who lived in a mountain village. She had never lived anywhere else and had attended the local Qur'an school. She favoured consulting practitioners of modern medicine but would turn to traditional healers if she failed to improve with modern medical care and treatment. This woman was very sure that mystical factors of all sorts could cause sickness and believed that the stomach ache, bloody stools and 'heart pain' (indicating the epigastric area), from which she had suffered for the past 13 years, was due either to the evil eye, to evil spirits or to jinns which were 'disturbing her blood'.

This woman had tried treatment from a medical assistant and a nurse, a feqi and a root specialist. She had been treated with tablets and injections, mihaya and roots from her respective practitioners, to no avail. She ascribed her condition to the day (in 1966) when she attended a circumcision party in another village and, during the dancing, first felt the pains.

Both these individuals acknowledged that their symptoms were sporadic, the man's did not keep him from daily routine activities but the woman's apparently enforced recumbancy at times. Both appeared fit at the time of interview, but the woman said that she was at that time preparing to go to the hospital in Nyala. They had both consulted a modern medical practitioner at first and had both been examined by a doctor, as well as other practitioners, before going to traditional healers. Both believed their complaints to be of a serious nature, the woman thought her's was very serious. It is unlikely that either of these individuals believed their original symptoms to have been caused by mystical agents. Both individuals claimed that they had initially consulted a modern medical practitioner, although this fact could not be ascertained with certainty.

From the list of causes collected together in Tables 17, 18, 19, from the survey questionnaire and from other informants, practitioners of medicine and lay informants, it can be seen that Fūr concepts of sickness cause are many and varied, although this cannot be said to be an exhaustive collection. During the administration of the survey questionnaire it became clear that the majority of causal factors cited by lay people were what could be termed natural or common sense (in Evans-Pritchard's terms), while practitioners of country medicine,

particularly fegis, often cited causes which had mystical overtones to say the least.

A word here about fegis. There is, of course, a great diversity within any group of professionals and among fegis in Darfur there is a continuum from the literate, travelled, knowledgeable urban fegi, entitled goni or fegi kabīr (literally 'big fegi'), to his almost illiterate rural counterpart. The former is a man of distinction and learning, to whom people come from afar to consult on many subjects, including healing; the latter is a farmer who has spent his formative years wandering with companions from one village to another, from teacher to teacher, until he has memorized by rote all or part of the Qur'an to the satisfaction of the teacher, and has then returned to his village to farm the land, with the right to use the title 'fegi' if he so wishes and to teach the Qur'an to others and to establish himself as a practitioner of country medicine.

Due to their varied backgrounds, fegis are bound to differ in their ideas and beliefs about sickness. All would agree that 'sickness comes from God' and is 'due to the will of God', but those who are more worldly-wise would also take into consideration the possibility of intermediate and immediate causes. A number of fegis pointed out that 'sickness comes from God, but in many ways' and then proceeded to give examples of immediate and intermediate causes.

Quite often, during the course of an interview, informants gave a number of factors as causes of sickness, although none of them actually articulated a system by which they classify sickness, they did make a

distinction between the causes upon which one could effect some change and the causes which human beings were known to be powerless to alter in any way. For example, factors such as hard work, the state of housing, diet, hygiene and certain conditions of the human body, it is believed, could be changed if the people could break out of the vicious circle of subsistence. Factors concerning climate, sickness transmitting agents (such as insects) and (accidental) trauma are regarded as being beyond human control. People frequently observe that such factors are due to 'the will of God' (iradat Allah, Ar.) or are 'from God' (min Allah, Ar.). To emphasize the fact that certain factors are due to the will of God alone, people add bas (enough) - iradat Allah, bas, or min Allah, bas. This sometimes means 'it is enough to know that it is from God' or 'it is from God and that's it - finish', which usually means an end to the discussion.

Thus, although they do not clearly articulate a system of classifying sickness cause, thereby also classifying sickness, there is the differentiation, particularly among practitioners of country medicine, of causes according to human ability to affect them.

Only one urban feqi, who was very sophisticated in comparison with all other feqis in Darfur, gave any indication of a theory of cause of sickness outside that already mentioned. This feqi had a brick-built house, with his treatment centre in one of the rooms. A covered veranda with chairs and benches formed the waiting room, and was always full of people waiting to see him. The consulting room was dim and filled with much furniture and book cases full of ancient looking tomes. The feqi

used two 'glasses' (thick convex lenses) which he said had been found in Jebel Marra, to help him determine the problems from which his clients suffered. This feqi is well-versed in many religious subjects and has read a number of the works of Arab medical scholars following the schools of Hippocrates and Galen, as well as those works containing both medical and magical aspects of healing. According to him, the four elements - earth, air, fire and water - must be balanced for good health. 'The body of man works by blood, but his nervous system is (naturally) filled with blood and air. If the nervous system becomes unbalanced and full of air, it will begin to work by air. If a man's mind works by air, doctors will say he is a madman (majnūn, Ar.)'. According to the feqi, poor eating habits are the cause of much digestive trouble and other ailments. For example, when a number of different kinds of food are gathered in the stomach, they cause the production of wind or air (hawa', Ar.) which causes small wounds in the lining of the stomach.

Another feqi spoke of many emotional problems which he had helped people through. According to him, 'if there is trouble between a man and his wife, among kinsmen, between friends and neighbours, or problems at a person's place of work, then people will be unhappy and then they are more likely to become sick'. People often go to see this feqi when they are contemplating taking their problems to the court, in order to see if there is anything he can do. According to him, he has been able to help quite a number of people to settle their differences.

These last two examples of the ideas and beliefs of two urban feqis, it should be emphasized, are unusual in Darfur. Their ideas have much more in common with those of a number of feqis interviewed in Khartoum.

5.4 CLASSIFICATION OF SICKNESS CAUSES

Human ability or inability to affect or control the factors believed to cause sickness have been shown, in the previous section, to be the main point of differentiation of causes of sickness. Even though a system of classification was not actually articulated, it was hinted at - more strongly by practitioners of country medicine than by lay informants.

According to Glick, in his search for a means by which medical systems can be studied cross-culturally, it is the identification of the loci of power and the ways in which power is manifested and dealt with as it relates to sickness and sickness behaviour, which constitutes this means, (Glick, 1957:32-34). The locus of the cause of sickness, Glick's 'disease-causing power' (ibid.:34) is either entirely extrinsic to the individual and outside his ability to control or affect in any way, or intrinsic, rendering the individual more susceptible physically and mentally or socially and ritually.

Originally, a natural - mystical differentiation was hypothesized for causes of sickness, which proved too simplistic a model for the Fūr material. However, such a model is useful when considering levels of operation of cause. As Gillies has shown for the Ogori (of Kwara State, Nigeria), the actors are probably much more discriminating about sickness

cause than their ethnographers might realize, (Gillies, 1976:358).

Gillies goes on to say that classification of disease is part of a much wider and general pattern of classification and thus, must be expected to vary with the religious and cosmological beliefs upon which people build their reality, (ibid.:392-393).

In West African societies, gods, witches and ancestral wrath abound to offer various levels of gravity of causal mechanism. The Fūr, as Muslims, do not have such a wide range of mystical phenomena from which to draw conclusions concerning the cause of sickness. Islam, in its slow but steady accommodation to and assimilation of the customs, beliefs and practices of the peoples who have been converted, has over the years moulded and remoulded the integrated indigenous faith within its embrace until nowadays all aspects of Fūr religious life are Islamic. The Muslim range of mystical phenomena among the Fūr is not, apparently, as intrusive into daily life as is that of the Ogori and other West African peoples.¹ As Gillies points out, the majority of people are theoretically Christians, 'but as elsewhere, many traditional beliefs and practices have survived the introduction of the world religions and come to co-exist fairly well with them', (ibid.:361). Here lies the difference between the Fūr and the Ogori - Islam has assimilated and accommodated, while Christianity has agreed to co-existence.

1. In three years working in Mid-West Nigeria, one was always conscious of the machinations of gods, witches and other mystical beings; in contrast, in Darfur it was necessary to seek out the reticent custodians of mystical lore.

Rather than an elaborate discrimination of mystical causes, the Fūr have a comprehensive repertoire of causes relating to the natural world about them and their efforts to subsist. Sickness, in the majority of cases, tends to be mild to moderate in severity and resolves itself when it has run its course. Therapeutic intervention merely alleviates the symptoms. Thus, coughs, colds and other chest infections, aches and pains, general malaise, disturbances of the digestive system, fevers, burns, soft tissue injuries and eye infections, which account for the major portion of sickness and which are going to resolve, with a full return to active life, do not require complicated explanation. The questions 'how?' and 'why?' can be answered by the natural level of causal factors. Whether the causal factor is from the extrinsic or intrinsic group, shown in the table below, will depend upon how the sick individual, his kinsmen or the practitioner of medicine evaluates the cause in relation to the power of the human being to exert control over it. This will supply the answer to the question 'how?'. In a straightforward case of recovery, the answer to the question 'why?' can be supplied by the comprehensive maxim 'it is the will of God'. If the situation is not so straightforward and recovery is slow, or the condition worsens or becomes chronic, resort may be made to the intermediate level of causation, where factors may provide a more comforting explanation of 'why?'.

TABLE 20 CAUSES OF SICKNESS

ULTIMATE LEVEL	GOD/WILL OF GOD	
INTERMEDIATE LEVEL (MYSTICAL)	<p>EXTRINSIC FACTORS</p> <p>1. Mystical agents</p> <ul style="list-style-type: none"> a) God/will of God b) fate/predestination c) jinns/spirits d) evil eye/sorcery 	<p>INTRINSIC FACTORS</p> <p>1. Social and ritual conduct</p> <ul style="list-style-type: none"> a) lack of observance of ritual purity b) lack of observance of sacred places/objects c) improper social conduct
	<p>2. Environmental conditions</p> <ul style="list-style-type: none"> a) climatic b) disease transmitting factors c) trauma 	<p>2. Factors affecting physical and mental state</p> <ul style="list-style-type: none"> a) work/fatigue b) diet - wrong/poor c) lack of personal hygiene d) inadequate housing e) medical conditions
IMMEDIATE LEVEL (NATURAL)		

In the table above factors causing sickness have been classified as either extrinsic or intrinsic in the immediate and intermediate levels of causation, i.e. below the ultimate level of the Deity. Extrinsic factors are those generally outside human control; intrinsic factors are those which increase individual susceptibility and are within human control or where human control is a possibility.

This framework for analysis has been adapted from models used by Douglas (1969:18) and Cosminsky (1972:108; 1977:330); it not only demonstrates the ability for human control over sickness but also identifies culpability. On the one hand the individual is seen as defenceless against powerful forces, while on the other he or she is guilty of conduct deemed to be 'not proper', or is negligent, increasing the susceptibility of the human body to sickness. Such a conceptualization would not be alien to the Fūr and it will be seen that the model could be appropriately employed to analyse the causes of sickness on pp.202 and 203.

The original supposition regarding causes of sickness was that there would be a natural-mystical dichotomy and that sickness would be interpreted as being due to some form of 'misdeed' rather than to 'mischance'. After collating the responses to the survey questionnaire, it became apparent that such a classification, along mystical-natural lines, would not be adequate for this material. However, within the framework illustrated above, there is possibility for a natural and a mystical level within both main categories. The first level of cause is concerned with self-evident factors based upon everyday experience

of naturally occurring events; the second level of cause is concerned with inferred factors based upon supposition about mystical beings and their relations towards the individual. Thus, the original concepts formulated for analysis can partly cope with the Fūr material but are not sufficient to indicate where the locus of Glick's 'disease-causing power' (Glick, 1967:34) is to be found. With four categories of cause, the disease-causing power can be located - either among extrinsic factors, in the realms of the environment or mystical agents far beyond human control, or among intrinsic factors, where the individual is culpable, having allowed the susceptibility of the human body to increase or (possibly even more worthy of blame) having been negligent over personal mystical status.

5.5 SURVEY QUESTIONNAIRE RESULTS

Of the individuals to whom the survey questionnaire was addressed, almost 50%, as Table 21 demonstrates, had suffered an episode of sickness within the previous four years and a number had some ailment at the time of interview. Thus, informants would have been responding to questions with various sentiments, from different angles. Two people denied ever having been sick.

TABLE 21 INFORMANTS GROUPED BY TIME OF SICKNESS

Time of sickness	rural no.	sample %	urban no.	sample %	Total no.	%
present	10	14.5	7	7.4	17	10.4
last year	13	18.8	27	28.7	40	24.6
1-4 years ago	10	14.6	28	29.6	38	23.3
5+ years ago	35	50.7	31	33.0	66	40.5
never sick	1	1.4	1	1.1	2	1.2
totals	69	100.0	94	100.0	163	100.0

Of those individuals sick at the time of interview ten were rural women, as Table 21 shows, nine of whom claimed to have been sick for some considerable time. A number considered that they had suffered the effects of their sickness for years in the form of a continuous state of lack of well-being and fairly minimal handicap or periodic discomfort. The two urban women and two urban men had suffered for some months rather than years. Length of their sickness episode, according to informants, is shown in Table 22 below.

TABLE 22 LENGTH OF SICKNESS EPIDIOSE: RURAL-URBAN COMPARISON

Length of sick- ness	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%	no.	%
1 day	-	-	-	-	-	-	-	-	2	4.3	2	2.1	2	1.2
2 - 6 days	1	2.4	3	10.7	4	5.8	10	20.8	15	32.6	25	26.6	29	17.8
1 - 2 weeks	5	12.2	6	21.4	11	16.0	10	20.8	14	30.4	24	25.4	35	21.5
3 - 4 weeks	3	7.3	11	39.3	14	20.3	8	16.7	4	8.7	12	12.8	26	16.0
4 + weeks	31	75.7	8	28.6	39	56.5	20	41.7	10	21.8	30	31.9	69	42.3
never sick	1	2.4	-	-	1	1.4	-	-	1	2.2	1	1.1	2	1.2
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

Islamic doctrine conceives of God as the ultimate cause. The actual 'being' of any 'thing' and the stimulus of any 'happening' are thus all due to God or the will of God. However, Muslims do also conceive of intermediate causes. As one feqi-informant explained, '... it comes from God, but in many ways'. The Fūr cite a variety of causes of sickness while believing that 'God' or the 'will of God' is the ultimate cause. As is shown in Table 23 below, it is a sizeable proportion of informants who gave replies relating to 'God' as the cause of sickness. The question asking all participants if they believed that sickness was due to the will of God, clearly showed that they did so. Attempts to

determine whether replies relating to 'God' or the 'will of God' were being used in the ultimate or intermediate sense were usually inconclusive. Most people believe that God sometimes actively causes an individual to be sick in a very positive way, rather than in the more general and ultimate sense mentioned above.

5.5.1 Causes of sickness: the hypothetical case

The causes of sickness shown in Table 23 below were elicited from informants by a general inquiry into their beliefs concerning sickness. As can be seen, a high proportion of informants claimed not to know when questioned in this way (the 'don't knows'). However, responses to later questions demonstrate that 'don't know' responses do not mean that informants have no idea about sickness cause. Rather, it indicates their inability or unwillingness to articulate their ideas and beliefs.

TABLE 23 CAUSES OF SICKNESS AMONG THE FÜR: THE HYPOTHETICAL CASE

Causes of sickness	no.	%
Environmental conditions	40	25.3
Mystical agents a) God	41	26.0
b) Other	7	4.4
Factors affecting physical and mental state	69	43.7
Social and ritual conduct	1	0.6
Total no. causes cited	158*	
Individual citing causes	105	
Don't knows	58	
Total no. informants	163	

* some individuals cited more than one cause.

This table shows the proportion of every type of sickness cause cited during the administration of the survey questionnaire, questionnaire 15, 'what do you believe causes sickness?'. Some individuals cited several causes, some were of the same category, others were not. Those causes which are of different categories are shown below, Table 24. Although hardly cited in this section, a few informants mentioned social and ritual conduct as cause of their own personally experienced episode of sickness, as will be seen later on in this chapter.

TABLE 24 CAUSES OF SICKNESS: DUAL CLASSIFICATION

Dual classification of causes of sickness	no.	%
a) Environmental conditions and factors affecting the physical and mental state	20	76.9
b) Mystical agents - God and other	2	7.7
c) Factors affecting physical and mental state and social and ritual conduct	1	3.9
d) (mystical agents) God and factors affecting physical and mental state	3	11.5
Total number of dual classifications	26	

When individuals cite factors from two different categories of sickness cause, they are frequently one from the intrinsic and one from the

extrinsic, shown in Table 20, page 218. The citing of causes from different levels of the same major category was much more unusual - only three informants did so, those of (b) and (c) above.

Replies to a question on sickness cause might be expected to be dependent upon many factors, such as the state of health of the informant and his or her close kin, friends and neighbours at the time of interview; the level of education of the informant and other, young, members of the family; and whether or not any members of the family had travelled, particularly to Khartoum or to the Gezira. By asking the questions of a relatively large number of people, it was hoped to elicit replies which would approximate to an inventory of possible causes of sickness that any one person might have in his or her repertoire.

The model illustrated by Cosminsky 'contains two orders of information involving different levels of causation'. (Cosminsky, 1977:331). First level concepts of causation are concerned with disturbance of body processes; the second level concepts are converted with religious, ethical and moral values, (ibid.).

Für ideas and beliefs regarding sickness can be said to be of three kinds of conceptualization, and to involve three levels of causation, as shown in Table 20. The first, immediate level involved natural, environmental factors and basic conditions of living and working, which might affect the physical and mental state of the individual. The second, intermediate level involves religious and social values and beliefs. The third level is the ultimate level of causation, the Deity, Allah, without whom nothing is and nothing happens.

'God' and the 'will of God' is shown in the extrinsic category and intermediate level of cause because there is a distinction here in Fūr thought regarding ultimate and intermediate cause. As the ultimate cause, God is the impersonal primum mobile. As the intermediate cause, it is believed an individual is sick actually 'by the will of God' or that the sickness is 'from God' - a more active assertion of His powers.

To complete the second section of the questionnaire are the four structured questions which seek to clarify points made by a number of key informants and practitioners of country medicine concerning the cause of sickness. The responses are as shown in the tables below:

TABLE 25 RESPONSES TO STRUCTURED QUESTIONS

a) Do you believe sickness is due to mischance/is accidental?

	Rural sample				Urban sample			
	women		men		women		men	
	no.	%	no.	%	no.	%	no.	%
yes	14	34.1	8	28.6	40	83.3	40	87.0
no	25	61.0	20	71.4	7	14.6	6	13.0
don't know	2	4.9	-	-	1	2.1	-	-
totals	41	100.0	28	100.0	48	100.0	46	100.0

b) Do you believe sickness comes as a punishment from God for misconduct/wrongdoing?

	Rural sample				Urban sample			
	women		men		women		men	
	no.	%	no.	%	no.	%	no.	%
yes	31	75.6	24	85.7	42	87.5	41	89.1
no	9	22.0	4	14.3	5	10.4	3	6.5
don't know	1	2.4	-	-	1	2.1	2	4.4
totals	41	100.0	28	100.0	48	100.0	46	100.0

c) Can jinns/shaytāns, the evil eye or sorcery cause sickness?

	Rural sample				Urban sample			
	women		men		women		men	
	no.	%	no.	%	no.	%	no.	%
yes	30	73.1	23	82.1	39	81.3	38	82.6
no	7	17.1	5	17.9	6	12.5	8	17.4
don't know	4	9.8	-	-	3	6.2	-	-
totals	41	100.0	28	100.0	48	100.0	46	100.0

d) Do you believe that sickness is due to God's will?

The response to this question was virtually 100% in the affirmative, the only negative response was from a woman who could not understand the question.

The responses, shown in Table 25, to the four structured questions indicate a belief in the possibility that all of the factors suggested by practitioners of medicine and key lay informants could cause sickness. On many occasions during the rural interviews, it was necessary to attempt to explain the question concerning 'mischance'. Although some people, particularly in the urban area were quite familiar with the concept of 'mischance', 'chance' or 'bad luck' and entertained this as a possible cause of sickness, many rural people positively rejected the idea as being contrary to Islamic dogma. Where God is the ultimate primum mobile, the question is irrelevant; it will not be pursued here. The rural and urban responses to the question may be an indication that among urban people, there is a less rigid interpretation of the concept of God as the ultimate cause.

In order to ascertain the extent of the part played by mystical agents - in particular, agents other than the Deity, such as jinns, the evil eye and sorcery - in Fūr beliefs about sickness causation, the questions shown below were scattered through the questionnaire.

- (i) What do you believe causes sickness? in Section II of survey
- (ii) Do you believe sickness can be caused by jinns/sorcery/the evil eye/the will of God?
- (iii) What is/was the cause of your sickness?
- (iv) Why do you think this has happened to you? in Section III/IV of survey
- (v) Do you think that jinns, shaytāns, sorcery or the evil eye caused your sickness

TABLE 26 COMPARISON OF RESPONSES REGARDING GOD AND OTHER MYSTICAL AGENTS AS CAUSE OF SICKNESS

Question		Cause of sickness			
		God		Other mystical agents	
Section II of survey	Q(i)	41/158	26.0%	7/158	4.4%
	Q(ii)	162/163	99.4%	130/163	79.7%
Section III and IV of survey	Q(iii)	14/163	8.6%	5/163	3.1%
	Q(iv)	28/163	17.2%	4/163	2.5%
	Q(v)	-	-	42/163	25.8

NB. In Q(i) the total in 158 = total causes cited
 Other questions, total is 163 = total sample

The last inquiry, regarding mystical causation, can only be said to have elicited an agreement as to possibility. Only in the case of a diagnosis of 'madness', or long-term or otherwise inexplicable sickness, did people talk with any earnestness about mystical agents.

As one of the questions to which this thesis is addressed is specifically concerned with the non-natural, supernatural or mystical aspect of theories of causation, it is necessary to look at the two entities comprising it in order to assess the importance of each one. Table 26 indicates how informants answered the questions set out above. As can be seen, although they had mentioned various possible causes while completing the questionnaire, no more than a quarter of the sample believed that their own episode of sickness could have been caused by mystical agents other than God.

Responses to the survey questionnaire and informal discussion would seem to indicate that Fūr ideas of causation can be conceived of as having three possible levels for explanation of sickness:- the ultimate cause (the Deity, Allah), the intermediate, possible, hypothetical cause, and then the immediate, probable, practical cause. At times all three levels may be telescoped into one, as when a personally experienced sickness is deemed only to have been due to the will of God. Quite often an extrinsic and an intrinsic factor are involved in causation. For example, a cold may be said to be directly due to having bathed at sunset - a factor within human control - but to be also due to the fact that the weather had not been good (cold, rainy or windy) - a factor beyond human control.

One of the tasks of this study is to document differences and similarities, particularly in the field of sickness and healing, among Fūr communities - rural and urban - and to endeavour to account for them. Certain features will be analysed to compare and contrast responses from rural and urban communities and from men and women. In this chapter, responses gained from a variety of questions concerning sickness cause are compared. Inquiries were made into the hypothetical and general view of sickness cause and then into ideas and beliefs about the cause of personally experienced sickness.

TABLE 27 GENERAL CAUSES OF SICKNESS: RURAL URBAN COMPARISON

	SICKNESS CAUSE	RURAL SAMPLE				URBAN SAMPLE							
		women no.	%	men no.	%	totals no.	%	women no.	%	men no.	%	totals no.	%
Extrinsic Factors	Environmental Conditions	4	9.8	3	10.7	7	10.1	3	6.3	5	10.9	8	8.5
	Mystical a) God Agents b) Other	1 3	2.4 7.3	6 -	21.6 -	7 3	10.1 4.3	13 -	27.0 -	14 1	30.4 2.2	27 1	28.7 1.1
	Mystical a) & b) Agents	-	-	1	3.6	1	1.4	-	-	1	2.2	1	1.1
	Extrinsic and Intrinsic Factors	3	7.3	4	14.3	7	10.1	8	16.7	8	17.4	16	17.0
Intrinsic Factors	Factors affecting physical and mental state	5	12.2	6	21.4	11	16.0	4	8.3	12	26.0	16	17.0
	Social and Ritual Conduct	-	-	-	-	-	-	-	-	-	-	-	-
	Factors affecting physical and mental state and social and ritual conduct	-	-	-	-	-	-	1	2.1	-	-	1	1.1
	Total citing causes Don't Knows Total Informants	16 25 41	39.0 61.0 100.0	20 8 28	71.4 28.6 100.0	36 33 69	52.2 47.8 100.0	29 19 48	60.4 39.6 100.0	41 5 46	89.1 10.9 100.0	70 24 94	74.5 25.5 100.0

The responses from both the rural and urban survey samples can be seen in Table 27 above and some conclusions and comparisons can be drawn.

The noticeable features are:-

- (i) the difference in proportions of both rural and urban respondents in citing extrinsic and intrinsic factors;
- (ii) the greater proportion of sickness attributed to God by the urban dwellers;
- (iii) the small proportion, mainly rural, citing other mystical agents as cause; and
- (iv) the larger proportion of rural 'don't knows'.

Some suggestions as to reasons for these points are relevant here.

Regarding (i), differences would point to a preference for allotting blame for cause of sickness where there is little or no chance or redress. The individual is seen as defenceless against powerful forces - a more comfortable situation than the punitive or retributive, where others might feel free to pass judgement. The attribution of cause to God or the will of God among urban dwellers, (ii), may indicate contact with those more knowledgeable in Islamic theology and, accordingly, an increasing uncertainty towards the importance of other mystical agents. The converse of (ii) might hold true for (iii), for learning in rural areas is dependent upon feqis who teach by rote learning rather than by lecture and discussion which might stimulate and direct the ideas of the young pupils. Lacking new and fresh ideas, it is not difficult to envisage the continuation of a narrower, rustic world view, passed on from one generation to another. As far as the last point, (iv), is concerned, even if the rural people are aware that urban ideas and beliefs are changing, they have

yet to reach the stage of shedding their own traditional and familiar beliefs and, presumably, would prefer to give the 'safer' 'don't know' response. This applies particularly to rural women. In fact the women of both rural and urban samples are slower than the men in changing their beliefs about sickness cause.

5.5.2 Causes of sickness: the case of personal experience

When asked about sickness they had personally experienced, informants replied usually with symptomatic descriptions of ailments, rather than disease names. Sometimes they gave single symptoms and at others, groups of symptoms. The most commonly cited symptoms were those of stomach pain, diarrhoeas and dysentery, general upsets of the digestive system and fevers, with or without headaches and joint pains. The table below shows the frequency of symptoms in a rural-urban comparison.

TABLE 28 GENERAL GROUPINGS OF SICKNESS SYMTOMS SUFFERED BY INFORMANTS

Sickness type (Symptom groups)		Rural sample				Urban sample			
		women		men		women		men	
		no.	%	no.	%	no.	%	no.	%
Stomach and digestive troubles	(42)	17	41.5	8	28.5	10	20.8	7	15.2
Fevers ± headaches ± joint pains	(43)	9	21.9	6	21.4	10	20.8	18	39.1
Aches and pains	(21)	6	14.6	4	14.3	6	12.5	5	10.9
Headache	(5)	-	-	-	-	4	8.3	1	2.2
Coughs, colds, chest troubles	(11)	-	-	6	21.4	1	2.1	4	8.7
Traumatic injuries	(10)	1	2.4	2	7.2	1	2.1	6	13.0
Female complaints, pregnancy problems	(10)	4	9.8	-	-	6	12.5	-	-
Other (including mental disturbances)	(19)	3	7.3	2	7.2	10	20.8	4	8.7
Never sick	(2)	1	2.4	-	-	-	-	1	2.2
Totals		41	100.0	28	100.0	48	100.0	46	100.0

Men's sickness is often associated with traumatic injuries, physical labour and environmental conditions; that of women with physical labour, environmental factors and other medical conditions. 'God' or the 'will of God' is believed by all to be the ultimate cause of sickness but this is often expressed in terms which indicate 'reason' for sickness rather than cause.

During informal discussions with women, and also with feqis and midwives (both country and modern), it became apparent that women suffer a good deal of discomfort, distress and pain due to what they refer to as 'women's troubles', obstetric and chronic gynaecological problems. However, women's troubles are not regarded as sicknesses unless, or until, they become so severe that the woman cannot carry out her daily routine and is very obviously unwell. Women are expected to be able to cope with the discomforts of being a woman. As in other African and Arab societies, a woman's 'real' role in the family and the community is that of reproduction - women legitimate themselves by their children - while their role as housekeeper and farmer is generally little valued. It may be that women do not regard, or at least do not admit to regarding women's troubles as sickness because as such they would seem to be admitting to failure in their real role. It may be also that women say they have stomach or digestive problems when they are suffering from other complaints (such as the gynaecological problems which are given less recognition). Several urban women described their sickness as 'kidney pain' (in the category 'other') and many described 'heart pain', which would seem to be equivalent to our own lay term 'heart burn'.

Conversation with women and with feqis, who give the majority of treatment to women with such problems, as well as giving prophylactic charms to those who are free of troubles, reveals that the women do usually presume that some sort of evil power is responsible for women's troubles. The evil eye is the most commonly cited cause.

Thus, it would seem that a proportion of distressing conditions suffered by women, which are believed to be due to some mystical intervention, are not thought of as sicknesses in the way that fevers and dysentery are recognized, unless they encroach upon the ability to participate in everyday activities. This could account partially for the lack of citings of mystical agents as cause of sickness, but would not account for the fact that men do not cite mystical factors either for sicknesses they suffer apart from trauma.

Mental problems, as might be expected, are believed to have mystical causes - evil spirits or jinns - but mental problems do not seem to be particularly prevalent among the Fūr, although many villages have their resident 'madman'.

Table 29 below indicates the cause of the sickness symptoms experienced by informants. The following table compares the causes elicited from the rural and urban informants.

TABLE 29 CAUSES OF SICKNESS SYMPTOMS

Sickness Symptom	Environmental factors			Mystical factors			Factors affecting physical and mental state			Social and ritual conduct			Don't know		
	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %
Stomach and digestive troubles (42)	5	13.2	11.9	6	42.9	14.3	1	50.0	2.4	6	19.3	14.3	1	25.0	2.4
Fevers (43)	15	39.5	34.9	3	21.5	7.0	1	50.0	2.3	7	22.6	16.3	-	-	-
Aches and pains (21)	1	2.6	4.8	2	14.3	9.5	-	-	-	4	12.9	19.0	2	50.0	9.5
Headaches (5)	-	-	-	1	7.1	20.0	-	-	-	2	6.5	40.0	-	-	-
Coughs and Colds (11)	3	7.9	27.3	1	17.1	9.1	-	-	-	4	12.9	36.3	-	-	-
Trauma (10)	10	26.3	100.0	-	-	-	-	-	-	-	-	-	-	-	-
Female Complaints (10)	1	2.6	10.0	-	-	-	-	-	-	5	16.1	5.0	-	-	-
Other (19)	3	7.9	15.8	1	7.1	5.3	-	-	-	3	9.7	15.8	1	25.0	5.3
Never sick (2)													11	15.3	57.9
Totals	38	100.0		14	100.0		2	100.0		31	100.0		4	100.0	
% of Total (163)		23.3			8.6			1.2			19.0			2.5	
													72	100.0	
														44.2	

TABLE 30 CAUSES OF PERSONALLY EXPERIENCED SICKNESS: RURAL-URBAN COMPARISON

Cause of sickness	Rural sample				Urban sample			
	women no.	%	men no.	%	women no.	%	men no.	%
EXTRINSIC FACTORS								
a) environmental factors	5	12.2	6	21.4	5	10.4	22	47.8
b) mystical - God factors - other	2 1	4.9 2.4	4 -	14.3 -	6 -	12.5 -	2 1	4.3 2.2
INTRINSIC FACTORS								
a) factors affecting physical and mental state	5	12.2	6	21.4	12	25.0	8	17.4
b) social and ritual state	1	2.4	-	-	3	6.3	-	-
DON'T KNOW	26	63.4	12	42.9	22	45.8	12	26.1
NEVER SICK	1	2.4	-	-	-	-	1	2.2
TOTAL	41	100.0	28	100.0	48	100.0	46	100.0

In the responses to questions about cause of personally experienced sickness, it will be noticed that few individuals expressed the belief that they had conducted themselves - either socially or ritually - in a way that would have rendered them susceptible to sickness as retribution for transgression. This, though was a cause of sickness offered by many informants during discussions which took place before the survey questionnaire was finalized and administered. The reason for this may be that, firstly, people tend not to be objective when analyzing the cause of personal sickness and, secondly, they may well decide not to discuss their short-comings with a stranger.

When the responses are analysed by sex as well as by habitation, it becomes obvious that it is the rural women who are the most susceptible to suggestions that mystical or non-natural agents might have caused them to become sick. However, when discussing personally experienced episodes of sickness, only a tiny minority of rural women suggested themselves that their sickness had been due to mystical agents such as jinns or the evil eye, as did an equally tiny proportion of urban women.

TABLE 31 MYSTICAL AGENTS AS CAUSE OF PERSONALLY EXPERIENCED SICKNESS

Mystical agents as cause of sickness	Rural sample				Urban sample			
	women		men		women		men	
	no.	%	no.	%	no.	%	no.	%
YES	22	53.7	5	17.9	7	14.6	8	17.4
NO	13	31.7	19	67.9	40	83.3	37	80.4
DON'T KNOW	5	12.2	4	14.3	1	2.1	-	-
NEVER SICK	1	2.4	-	-	-	-	1	2.2
Totals	41	100.0	28	100.0	48	100.0	46	100.0

Discussion of the effect of living in an urban environment and formal education is taken up again towards the end of this present chapter. The next set of tables compares rural and urban samples as informants cited the cause of personally experienced episodes of sickness.

When questioned further as to why they should have suffered sickness, similar types of replies to those obtained earlier were elicited. The relative variation between categories of response is shown below, Table 30. When pressed to consider the cause of their sickness a second time, it will be seen that people, who may not have been quite so certain about environmental factors or those affecting the physical and mental state, turn to the Deity as cause or confess not to know the cause. Both these responses may be regarded as being 'safer' and also effectively put an end to discussion on the topic.

TABLE 32 CAUSES OF PERSONALLY EXPERIENCED SICKNESS: COMPARISON OF RESPONSES TO Q.23 AND Q.31 OF SURVEY QUESTIONNAIRE

Causes of sickness	Q.23		Q.31	
	total	sample	total	sample
	no.	%	no.	%
EXTRINSIC FACTORS				
a) environmental factors	38	23.3	24	14.7
b) mystical - God	14	8.6	28	17.2
agents - other	2	1.2	3	1.9
INTRINSIC FACTORS				
a) factors affecting physical and mental state	31	19.0	24	14.7
b) social and ritual conduct	4	2.5	2	1.2
DON'T KNOW	72	44.2	80	49.1
NEVER SICK	2	1.2	2	1.2
Total	163	100.0	163	100.0

Some individuals who had experienced sickness indicated that they believed that certain mystical agents - other than the Deity - were possibly responsible for their indisposition. This was so in both rural and urban communities.

TABLE 33 MYSTICAL AGENTS AS CAUSE OF SICKNESS

Mystical agents as sickness cause	Rural sample		Urban sample		Total	
	no.	%	no.	%	no.	%
YES	27	39.1	15	15.9	42	25.8
NO	32	46.4	77	81.9	109	66.9
DON'T KNOW	9	13.1	1	1.1	10	6.1
NEVER SICK	1	2.4	1	1.1	2	1.2
TOTAL	68	100.0	94	100.0	163	100.0

The general, hypothetical inquiry into the cause of sickness, and the inquiry into the cause of personally experienced sickness, both drew a majority of responses from those grouped under the category of extrinsic factors of sickness causation. Such responses indicate the favouring of belief in causation by factors over which man has no power. Thus, also, man appears to be blameless in the deviation from the generally accepted norm of health.

5.6 EFFECTS OF URBAN LIVING AND EDUCATION ON BELIEFS ABOUT SICKNESS CAUSE

Although the figures are very small, Table 34 does indicate an increasing awareness of extrinsic factors, in particular, and also of intrinsic factors believed to be causative of sickness by rural people who are gradually being exposed to aspects of urban life. The 'don't knows', though decreasing with exposure to urban life, still form a sizeable proportion, even among the urban population sample. Approximately half the urban population sample, both men and women, were born and have lived all their lives in an urban area. Some have lived in Nyala and el-Fasher, larger and more urbanized centres than Zalingie, others have lived in similar small market towns in Darfur, a few in Kordofan.

TABLE 34 EFFECT OF URBAN LIVING ON BELIEFS ABOUT CAUSE OF SICKNESS

(a) Rural sample

Causes of sickness	Years of urban living								totals	
	0		-1		1-4		5+			
	no.	%	no.	%	no.	%	no.	%	no.	%
Extrinsic factors	12	33.3	7	38.9	7	50.0	1	100.0	27	39.1
Intrinsic factors	2	5.6	4	22.2	3	21.4	-	-	9	13.0
Don't know	22	61.1	7	38.9	4	28.6	-	-	33	47.8
Total	36	100.0	18	100.0	14	100.0	1	100.0	69	100.0

(b) Urban sample

Causes of sickness	Years of urban living								totals	
	0		-1		1-4		5+			
	no.	%	no.	%	no.	%	no.	%	no.	%
Extrinsic factors	-	-	-	-	3	75.0	51	57.3	54	57.5
Intrinsic factors	-	-	-	-	-	-	15	16.9	15	16.0
Don't know	-	-	1	100.0	1	25.0	23	25.8	25	26.6
Total	-	-	1	100.0	4	100.0	89	100.0	94	100.0

TABLE 35 THE EFFECT OF EDUCATION ON BELIEFS ABOUT SICKNESS CAUSE

(a) Rural sample

Causes of sickness	No schooling		Educational status				Totals	
	no.	%	Qur'an school no.	%	Government school no.	%	no.	%
Extrinsic Factors	-	-	27	39.1	-	-	27	39.1
Intrinsic Factors	-	-	9	13.0	-	-	9	13.0
Don't Know	-	-	33	47.9	-	-	33	47.9

(b) Urban sample

Causes of sickness	No schooling		Educational status				Totals	
	no.	%	Qur'an school no.	%	Government school no.	%	no.	%
Extrinsic Factors	17	48.6	17	68.0	20	52.8	54	57.4
Intrinsic Factors	3	8.6	5	20.0	7	20.6	15	16.0
Don't Know	15	42.8	3	12.0	7	20.6	25	26.6
Total	34	100.0	25	100.0	35	100.0	94	100.0

The tables above, 35(a) and 35(b), are perhaps more indicative of a decreasing of 'don't know' responses when information is sought about sickness, than of an increase in belief that any one particular type of factor is causative. The figures would seem to indicate that formal education and urban life are equally important factors in the increasing awareness of the various causes by rural and semi-urbanized people of sickness. Perhaps, more positively, it can be said that however long rural

people have lived in an urban area before returning to take up the rural life once more, for them the environment, especially the climate, is the key factor in the cause of sickness. This is, perhaps, in keeping with their closeness to the land and their understanding of their ecological niche. Urban people, whatever their type of education, equally favour God and the environment (and within this group, equally favour the climate and disease transmitting factors). This may be understood to be in keeping with a stronger accent being placed upon religion, where people are conscious of their Islamic faith and their 'Arabness', for these signify their belonging to the Muslim Northern Sudan - rather than being designated as inhabitants of one of the furthest and least developed of its regions. All Fūr can trace back to their first Arab ancestor - perhaps only a tenuous link with an early sultan - but this, with a strong and uncomplicated faith will tend to enhance responses citing God as cause, particularly in answer to a foreigner or a stranger. Rural people do not yet feel this need as yet for assertion of 'belonging'. They seem to still feel their ties to the land, to their dar. This may account in some way for a particular sensitivity to environmental factors as causative of sickness.

Rural informants, due to lack of opportunity, only attended Qur'an school and thus, a comparison between the two groups of informants (rural and urban) regarding beliefs according to education, is not entirely satisfactory. However, within the two groups attending the Qur'an school, the proportion of urban 'don't knows' was by far the smaller. The sizeable proportion of urban people with no schooling (mainly women) who cited extrinsic factors as cause of sickness, would tend to suggest that there is

a more complex background to changing beliefs. It is suggested here that urban living and 'modernization' (rather than 'urbanization'), a change in thought and belief and way of life while continuing to live in the same place, rather than a rush to the towns and to built-up urban areas, is what is taking place in Darfur. Travel and formal education add to the dissemination of information. Where a wide and varied generalized type of knowledge is found among communities without a formally educated older generation, there must be easy and relaxed social relations between the sexes and the generations. This is certainly so among the Fūr communities visited. Women are avid listeners to the tales of those who have travelled or spent their schooldays in far-off urban areas. They are eager to learn about new and different things and to experiment with new therapies and ideas of sickness cause.

Although one can only speculate about which causes of sickness are new to the Fūr and have been introduced from modern medicine, it would not seem too presumptive to suggest that a number of those subsumed under the category of 'disease transmitting factors' are such. The Fūr use terms such as 'baktiriya' and 'mikrūb' fairly frequently when discussing sickness and are very familiar with 'malāriya'.

Feqis, the teachers, and proprietors usually, of Qur'an schools may be responsible for many peoples' beliefs and ideas about sickness. The way in which they conduct their own lives will have a bearing upon their teachings. Rural feqis tend to be either farmers who teach and heal on a part-time basis or to be more religiously active men who encourage a more spiritual or mystical image in their teaching and healing. Urban feqis may be

straightforward teachers and healers, following an orthodox religious path or they may again be mystics, well-versed in somewhat unorthodox ṣūfi ritual. Some are interested in making themselves appear powerful by their ability to command spirits, desiring to live and work within an atmosphere revered by ordinary people; one which has mystique and which will add to their celebrity. Such feqis particularly and also more sober individuals, are likely to generate in their pupils and their clients a respect for mystical agents as cause of sickness - as demonstrated by the response to inquiries into this possibility. If they are sincere Muslims, which one would judge most to be, they will also teach that God is the ultimate cause. Dependent on the character of the individual feqi will be the nature of the bias of his teaching, healing and his beliefs about sickness.

Barei is a village within the area of influence of the feqis of Turra, a most sincere, devout and orthodox religious family. They are in contrast to the feqis of Kongyo, residing in villages in hills west of Zalingie, who are reputed to be very powerful, to be able to control many spirits and to perform magical acts. The sobriety of the teaching of the local feqis may well have influenced the beliefs of informants in Barei. Even though four informants suggested that sickness was due to mystical agents other than God, the majority belief was in environmental factors. Those who suggested mystical agents were those suffering some emotional stress or who had felt their sickness to be prolonged and unexplained by other means.

To sum up this section on the effects of urban living and education on beliefs about sickness cause, one can say that together these two factors, along with travel, have been instrumental in increasing peoples' general knowledge about causes of sickness. Even rural people with no formal education have knowledge of and are using terminology associated with modern medicine. Many of the causes of sickness cited by informants would seem to have their basis in modern medical thought, though of course this cannot be more than speculation. It is usually men who travel and attend school for a longer period (formal and Qur'an) and it is they who have more time for discussion with their friends and relatives. Thus, it is men who gain the knowledge and pass it on to women - in both rural and urban situations. Urban men would certainly seem to have developed beliefs of sickness cause which are more in accordance with modern medicine than rural men, or women of both situations (see Table 30 Factors causing personally experienced episodes of sickness).

5.7 SUMMARY

After a brief glance at the Fūr concept of health this chapter has concentrated upon sickness and the way it is conceptualized by the Fūr. The original hypothesis categorizing causation as being natural or mystical proved inappropriate for analysis of the Fūr case; it was found that causes of sickness could more pertinently be categorized according to the power man might exert over them.

Extrinsic and intrinsic categories of factors responsible for sickness were devised. Extrinsic factors are those generally outside human control (environmental and mystical). Intrinsic factors are those which increase human susceptibility and are within human control, or where human control is a possibility (factors affecting physical and mental state, and social and ritual conduct). The last category and that of mystical factors other than God, were offered fairly infrequently as cause of sickness; it is suggested that this is due unconsciously, to lack of objectivity in a situation where the individual might appear to be responsible for his or her own deviation from the norm. Also, it is suggested that people are not used to articulating their ideas about sickness cause.

Generally the Fūr are a pragmatic people, living close to nature, their livelihood dependent upon the climate. Environmental conditions directly affect them, as well as their crops. Their living conditions are basic, probably just adequate in most cases, but they are unable to cope with extremes. They have acquired some of their medical knowledge by their association with urban life and with more sophisticated individuals. They possess a varied repertoire of sickness causes which probably has a mixed background in local, Arabic and modern medicine.

Urban living, of even a few years duration, is seen to increase awareness of sickness cause and may be a more influential factor than formal education. Generally speaking it is men who initially disseminate and make use of new and different ideas due to their greater possibilities for travel, education and discourse but, as will be seen later, it is

women who put the newly acquired knowledge into practice, always being eager to try new therapies, particularly those of modern medicine.

The next chapter will discuss the way in which the Fūr choose the practitioner by whom they will be treated. The chapter will go on to analyse the way in which sickness is conducted, from the responses to the survey questionnaire and will describe the consultation of two practitioners, a fegi and a community health worker.

Chapter 6

CONDUCT OF SICKNESS

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6.1 INTRODUCTION

When an individual (and/or his or her kinfolk) acknowledges that the state of health of the individual has departed from the normal, the conduct of the sickness commences. The way in which the episode of sickness (or injury) is managed is dependent upon whether or not a practitioner of medicine is to be consulted or if the individual will carry out self treatment. Only if the injury or sickness does not impair normal activity is it likely to be more or less ignored; the great majority of Fūr would consult a practitioner of medicine in most instances, though they may go no further than to consult the family home therapist on a single occasion. If the decision to consult a practitioner of medicine is taken, then the choice of practitioner has to be made.

Some choices, of course, are more dependent upon the sickness or injury than upon other factors, such as time, distance and cost, and a sick person will either choose the specialist practitioner of country medicine in the relevant field or a practitioner whose range of therapy is more generalized. He or she is unlikely to choose a specialist in an unrelated field.

6.2 THE CHOICE OF PRACTITIONER OF MEDICINE

Until 1979 there were medical assistants and nurses running the 6 dispensaries and 12 dressing stations in the Western District of

Southern Darfur. Due to population movement away from some areas where water has become scarce, and with the decrease in epidemic diseases, there has been a decrease in the use of some medical units. This has led to the general running down of many of the modern medical treatment units, a situation which has been exacerbated by the nationwide problem actually obtaining adequate supplies and moving them to the more remote rural areas of this vast country. During 1979, the first community health workers in Darfur finished their 9-month training courses and returned to their home villages to set up and run primary health care units. Of the 118 community health workers who finished their training in Southern Darfur in 1979, 16 took over the running of dressing stations. One of these was in the village neighbouring Barei. Another community health worker was stationed in the market village of Rokirroh.

The arrival of the two health workers has meant that modern medicine is now made available to the villagers of this part of Jebel Marra, at the primary health care level. The health workers are energetic young men who have grown up in the area, who know almost everyone they meet and who are related by kinship or marriage to the majority of the population.

As already mentioned, three visits were made to the mountain village and the small survey of the population was carried out during the first and second visits in November 1978 and June 1979, just prior to the arrival of the newly qualified community health workers. By the time of the third fieldwork visit, in April 1980, there was a discernible change in attitude towards modern medicine.

6.2.1 The hypothetical case

In the second section of the questionnaire, informants were asked (questions 11 and 14) which practitioner of medicine they would prefer to consult if either they or their children were to become sick. They were also asked what kind of treatment they would expect and, if they were not cured, what they would do next. According to their responses (collected prior to the arrival of the community health worker), the Fūr individuals interviewed would choose to be treated by a feqi, a herbalist or 'owner of roots', a bone setter, a practitioner of modern medicine, "someone who gives injections" (usually a general practitioner) or by themselves - rural men preferring the latter choice. Women did not suggest treatment by a rope-midwife when asked their choice of therapist, but said that they would call for one at the appropriate time (if not attended by a modern medical midwife) when asked specifically about this. This factor would seem to add to the evidence that childbirth is not considered to be a deviation from health by the Fūr, particularly if it is an uncomplicated procedure. A proportion of individuals suggested that they would consult two healers concurrently, or would treat themselves as well as consulting another. Some rural people showed a preference for treatment by a group of people gathered together to perform Cazīma (reciting prayers).

Frequently individuals were not specific about which country therapist they would choose - only six specified one of those mentioned above. Thus, in the table below, they have been grouped together with those who chose an unspecified member of the group of 'country practitioners'.

TABLE 36 PRACTITIONER PREFERRED BY RURAL AND URBAN FÜR

Practitioner	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%	no.	%
Country	12	29.3	2	7.1	14	20.3	6	12.5	1	2.2	7	7.4	21	12.9
General	-	-	1	3.6	1	1.5	-	-	-	-	-	-	1	0.6
Country & modern medical	8	19.5	2	7.1	10	14.5	2	4.1	-	-	2	2.1	12	7.4
Modern medical	19	46.3	8	28.6	27	39.1	39	81.3	39	84.8	78	83.0	105	64.4
Self	-	-	11	39.3	11	15.9	1	2.1	5	10.8	6	6.4	17	10.4
Self & other	2	4.9	4	14.3	6	8.7	-	-	1	2.2	1	1.1	7	4.3
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

If the first healer should fail to bring about a cure, some 75% of Für would prefer to change to another therapist. Although the modern medical practitioner proves to be the preferred therapist of the majority of Für, if they should fail to recover or recovery proves to be protracted, the help of country practitioners would be sought in many cases, others (mainly rural people) would treat themselves, as the table below shows.

TABLE 37 PRACTITIONER PREFERRED FOR SUBSEQUENT CONSULTATION

Practitioner	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Country	12	29.3	6	21.4	18	26.1	22	45.8	22	47.9	44	46.8	62	38.0
General	1	2.4	-	-	1	1.5	-	-	-	-	-	-	1	0.6
Country & modern medical	3	7.3	-	-	3	4.3	1	2.1	2	4.3	3	3.2	6	3.7
Modern medical	11	26.8	9	32.1	20	29.0	18	37.5	20	43.5	38	40.4	58	35.6
Self	13	31.8	8	28.6	21	30.4	7	14.6	2	4.3	9	9.6	30	18.4
Self & other	1	2.4	5	17.9	6	8.7	-	-	-	-	-	-	6	3.7
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

Table 38 below shows practitioners of modern medicine and self-therapists to be the practitioners most frequently consulted a second time, when a subsequent consultation is deemed necessary.

TABLE 38 SECOND CONSULTATIONS OF ORIGINAL PRACTITIONERS

Practitioner	Initial consultation		Second consultation of same practitioner		% of first choice
	no.	%	no.	%	
Country	21	12.9	2	1.2	9.1
General	1	0.6	-	-	-
Country and modern medical	12	7.4	-	-	-
Modern medical	105	64.4	33	20.2	31.0
Self	17	10.4	5	3.1	29.4
Self and other	7	4.3	-	-	-
Total	163	100.0			

The choice of practitioner for a child restates the general preference for a practitioner of modern medicine, at least for first consultation, as the table below indicates.

TABLE 39 PRACTITIONER PREFERRED FOR CHILD: RURAL-URBAN COMPARISON

Practitioner	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Country	7	17.0	3	10.7	10	14.5	3	6.3	-	-	3	3.2	13	8.0
General	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Country & modern medical	10	24.4	4	14.3	14	20.3	6	12.5	5	10.9	11	11.7	25	15.3
Country or modern medical	5	12.2	3	10.7	8	11.6	1	2.1	-	-	1	1.1	9	5.5
Modern medical	17	41.5	8	28.5	25	36.2	37	77.0	37	80.4	74	78.7	99	60.7
Self	-	-	5	17.9	5	7.2	-	-	1	2.2	1	1.1	6	3.7
Self & other	2	4.9	5	17.9	7	10.2	1	2.1	3	6.5	4	4.2	11	6.8
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

The apparent differences between rural and urban people in choice of practitioner, shown in the tables above, may be dependent upon the facilities available in the situations studied. Although no survey was carried out on the last visit to the rural area, there was a certain amount of enthusiasm for treatment by modern medical practitioners since the new community health worker had taken up his post.

The community health worker, as already mentioned, is related to one of the original Barei families; it is this fact probably, more than any other, which has influenced villagers in their decision about the type of healer they would prefer to consult. In most instances the rural people indicated that they prefer to consult a kinsman, whereas urban people indicated their preference for a Fūr practitioner, though both would consult an outsider (Sudanese or foreigner) if, in their view, he or she had the medicines and the skill to cure them. Many people had either experienced modern medicine personally or had observed family members receiving treatment from the community health worker during the four or five months in which he had been in charge of the dressing station. They seemed to be favourably impressed with his care and attention to their problems and were anxious that he should be supplied with more drugs. The fact that supply never meets demand,¹ where drugs are concerned in rural areas, is perhaps the main reason for people treating themselves or consulting a practitioner of country medicine, either concurrently, or consecutively with their consultation of a practitioner of modern medicine.

The tables above indicate that the rural people at the time of interview did not have a clear-cut preference; their choices for their children are not too dissimilar from their own choices. It can only be assumed that the change in the choice of healer noted during the later visit, is due also to the introduction of the primary health care system and the policy to train young villagers who will return to their homes to work.

1. During the period of fieldwork, sometimes only a third of the quantities ordered were received by the medical stores in Zalingie in the quarterly delivery of supplies - said to be due to shortage of stock in the Ministry of Health Stores in Khartoum.

The tables also indicate that, although urban people are keen to try modern medicine, it may fall short of their expectations and so they turn again to more familiar medical therapists and therapies. (It is not uncommon for people to take miḥaya along with modern medicine to 'make sure' of a cure.) This is significant when considering social change and would seem to point to the recency of the change of choice, even in the urban area. It should be noted, however, that it is not only those who would first seek treatment from modern medical practitioners who would tend to choose another healer for a second therapy; those who would first consult a traditional healer would also, in general, not return for further treatment, but would ideally consult another individual.

The following question enquired into the type of treatment the individual would expect from his or her preferred practitioner of medicine.

TABLE 40 THERAPY EXPECTED FROM PREFERRED PRACTITIONER: RURAL-URBAN COMPARISON

Therapy	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
<u>miḥaya</u>	11	26.8	14	50.0	25	36.2	5	10.4	3	6.5	8	8.5	33	20
roots/plants trees	2	4.9	-	-	2	2.9	-	-	1	2.2	1	1.1	3	1
country medicine	-	-	-	-	-	-	2	4.2	1	2.2	3	3.2	3	1
Country & modern medicine	7	17.1	5	17.9	12	17.4	1	2.1	1	2.2	2	2.1	14	8
Examination & relevant treatment	-	-	-	-	-	-	-	-	3	6.5	3	3.2	3	1
necessary medicines/ drugs	8	19.5	-	-	8	11.6	11	22.9	16	34.8	27	28.7	35	21
tablets/ injections/ capsules/ other specific drugs	13	31.7	9	32.1	22	31.9	27	56.2	21	45.6	48	51.1	70	43
don't know	-	-	-	-	-	-	2	4.2	-	-	2	2.1	2	1
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100

People preferring specific country practitioners, naturally, expected to be treated according to the techniques of those healers - the feqi would use miḥaya, the herbalist, roots and other plant materials - although they might state simply that they would expect to be treated by 'country medicine', tibb el-balady. Of the individuals who preferred a modern medical practitioner or a general practitioner, 70 stated specifically the type of drugs they expected to be used in their treatment; the majority preferred 'the injection' (el-hugan¹) or 'the needle' (el-ībrah), which they considered to be the best possible type of therapy, having the most reliable results and acting quickly.

6.2.2 Practitioner chosen during an episode of sickness

In sections 3 and 4 of the questionnaire informants were asked (questions 27 and 51) which practitioner they had chosen during a previous episode of sickness at the time of interview. Table 21 shows that 17 individuals were sick at the time of interview, 40 had been sick during the previous year, 38 between one and four years ago and 66 around five years and more ago. Two claimed that they had never been sick.

In the episode of sickness in question the majority of Fūr chose to consult a practitioner of modern medicine, as Table 40 above shows. Their choice for a second consultation is also indicated, though it appears relatively few people sought further treatment. Others were either restored to health or simply preferred to 'remain at home' until well.

1. el-hugan (Ar. coll.) or el-hugan (Ar.)

TABLE 41 PRACTITIONER CHOSEN INITIALLY DURING AN EPISODE OF SICKNESS:
RURAL-URBAN COMPARISON

Practitioner	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Country	8	19.6	8	28.6	16	23.2	5	10.4	5	10.9	10	10.7	26	15.
General	5	12.2	-	-	5	7.3	-	-	-	-	-	-	5	3.
Country & modern medical	6	14.6	2	7.1	8	11.6	1	2.1	2	4.3	3	3.2	11	6.
Modern medical	14	34.2	7	25.0	21	30.4	39	81.2	34	74.0	73	77.6	94	57.
Self	-	-	4	14.3	4	5.8	2	4.2	2	4.3	4	4.2	8	4.
Self & other	1	2.4	3	10.7	4	5.8	-	-	-	-	-	-	4	2.
No treatment	6	14.6	4	14.3	10	14.5	1	2.1	2	4.3	3	3.2	13	8.
Never sick	1	2.4	-	-	1	1.4	-	-	1	2.2	1	1.1	2	1.
Totals	42	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.

Only one individual who consulted a practitioner of country medicine initially, returned to the same therapist when he needed further treatment. Four individuals consulted the practitioner of modern medicine a second time. All other individuals seeking further treatment consulted different practitioners, as shown below.

TABLE 42 SUBSEQUENT CHOICE OF PRACTITIONER DURING AN EPISODE OF SICKNESS: RURAL-URBAN COMPARISON

Practitioner	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Country	1	2.4	-	-	1	1.5	3	6.3	1	2.2	4	4.2	5	3.1
General	1	2.4	-	-	1	1.5	-	-	-	-	-	-	1	0.6
Country & modern medical	-	-	1	3.6	1	1.5	-	-	-	-	-	-	1	0.6
Modern medical	5	12.2	-	-	5	7.2	1	2.1	1	2.2	2	2.1	7	4.3
Self	1	2.4	-	-	1	1.5	5	10.4	1	2.2	6	6.4	7	4.3
Self & other	-	-	-	-	-	-	-	-	-	-	-	-	-	-
No treatment	32	78.1	27	96.4	59	85.3	39	81.2	42	91.2	81	86.2	140	85.9
Never sick	1	2.4	-	-	1	1.5	-	-	1	2.2	1	1.1	2	1.2
Totals	42	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

Table 41 shows how rural and urban men and women differed in their choices. Rural people do not show such a clear preferential choice as do urban dwellers. A number of rural women received an injection of modern medical drugs from a general practitioner although none had suggested they might turn to such a practitioner beforehand. It is easy to understand why help is sought from this kind of practitioner. People wishing to receive modern medical treatment do not have time, in the busy farming season, the money or the inclination to go in search of a practitioner of modern medicine. They can, however, easily receive

treatment from a local injection specialist once it is decided that an injection is the therapy required. The practitioner may, himself, have the drug, or it may be purchased at the local market. By being treated in this way, the rural individual can obtain the type of treatment he or she desires, at a convenient time and without travelling.

Rural men, having indicated that they preferred to treat themselves, are seen not to have done so to the extent of their preference; instead, they have been treated by a practitioner of country medicine. This is most commonly seen in the case of individuals who have been treated by a kinsman, often a feqi, who would take over the treatment of his relative if he found him sick. The sick person might also ask his kinsman to make miḥaya for him if he felt unwell. While feeling fit and well at the time of inquiry, it is likely that the rural men did not take into consideration the basic human need for sympathy and attention during times of sickness, when they claimed that they preferred to treat themselves.

Informants were then asked why they had chosen the practitioner. Individual country practitioners are often chosen by urban dwellers because they are well-known in the area or have previously helped a friend or relative. Urban practitioners who have specialized in certain treatments or who are full-time practitioners, especially those who have had one or two spectacular successes, gain a reputation far and wide. In the more remote rural areas, healers tend to be less specialized and are often chosen because of their kinship relationship to the sick person. However, if some specialized treatment is needed, the healer with the appropriate skill or knowledge is asked to treat the sick person, either directly or through a third party. If living at a distance, the sick person may travel

to the practitioner of country medicine or a messenger may go to bring back the practitioner or his prescribed therapy.

Practitioners of modern medicine are not usually chosen by such personalized means as are practitioners of country medicine. As mentioned earlier, the medical officer and perhaps also the medical assistant and nurses may not be natives of the area; being government employees, modern medical practitioners can be posted to other parts of the country for periods of time. Some stay for many years. Those who do work in their home areas may be consulted because of kinship relations and this is the case with the community health workers, who are specifically trained in order that they may return to their home villages to work. Thus, while urban dwellers probably chose practitioners of modern medicine simply because they wish to be treated with modern medical drugs, the choice made by rural people is not quite so straightforward. They may, of course, decide to try both methods of treatment. If individuals do choose to be treated with modern medical drugs, it may mean that they have to travel to one of the urban centres to obtain the drugs, a point in favour of country medicine.

From time to time throughout the year in small urban centres, as well as in remote rural areas, drug stocks are exhausted simply because the supply is inadequate. This may be because supply cannot keep up with demand or because supplies are delayed due to the rains or fuel shortages. Thus, family relationships, availability of drugs and distance to obtain drugs may all affect the choice of healer made by rural people.

Tables 41 and 42 are designed to indicate the influence of sickness cause on practitioner choice and the influence of sickness type on therapy choice. (Therapy type and practitioner are more or less interchangeable as numerical values, except that the general practitioner and modern medical practitioner are grouped together to give modern medical drug therapy.)

As can be seen in Table 43 there is a bias towards the practitioner of modern medicine in all types of sickness cause, though this is less marked in the case of mystical factors (where God is believed to be the cause). Here the practitioner of country medicine is chosen by a sizeable proportion of informants. When therapy choice is examined according to sickness type, Table 44, there is a marked preference for modern medical therapy, except in the case of coughs and colds, where country medicine is preferred and self treatment often occurs.

Among both rural and urban communities a greater proportion of women than men consulted a practitioner of modern medicine and partook of modern medical drug therapy. This is, perhaps, an indicator of women's more experimental nature; it is a fact, also that women have more to do with modern medicine. Women are the carers of their children when sick as well as of the other members of their families. This involves them in visiting hospitals, dressing stations and dispensaries and in such places they inevitably meet other women doing the same thing and they discuss the various treatments they have experienced or witnessed. Men are much more conservative. The reluctance to discuss sickness has been noted elsewhere and men probably do not experience the degree of involvement

TABLE 43 INFLUENCE OF SICKNESS CAUSE ON PRACTITIONER CHOICE

Sickness cause	Country			Modern medical			Practitioner Country and modern medical			General practitioner			No treatment		
	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %
EXTRINSIC FACTORS															
a) environmental factors	(38)	2	5.9	27	28.7	71.1	4	26.7	10.5	1	20.0	2.6	4	30.7	10.5
b) mystical - God factors - other	(14)	5	14.7	6	6.4	42.9	2	13.3	14.3	-	-	-	1	7.7	7.1
	(2)	-	-	-	-	-	2	13.3	14.3	-	-	-	-	-	-
INTRINSIC FACTORS															
a) Factors affecting physical and mental state	(31)	5	14.7	19	20.2	61.2	2	13.3	6.5	2	40.0	6.5	3	23.1	9.7
b) social and ritual state	(4)	-	-	4	4.3	100.0	-	-	-	-	-	-	-	-	-
Don't Know	(72)	22	64.7	38	40.4	52.8	5	33.3	6.9	2	40.0	2.8	5	38.5	6.9
(Never sick - 2)															
Totals	34	100.0		94	100.0		15	100.0		5	100.0		13	100.0	
% of Total (163)		20.9			57.6			9.2			3.1			8.0	

TABLE 44 INFLUENCE OF SICKNESS TYPE ON THERAPY CHOICE

Sickness type (symptom groups)	Therapy											
	Country medicine			Modern medicine			Country and modern medicine			No treatment		
	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %	No	Col %	Row %
Stomach and digestive troubles (42)	7	20.6	16.7	25	25.3	59.5	5	33.3	11.9	5	38.5	11.9
Fevers (43)	6	17.7	14.0	31	31.3	72.1	5	33.3	11.6	1	7.7	2.3
Aches and pains (21)	5	14.7	23.8	14	14.1	66.6	1	6.7	4.8	1	7.7	4.8
Headaches (5)	-	-	-	4	4.0	80.0	-	-	-	1	7.7	20.0
Coughs and colds (11)	5	14.7	45.4	3	3.0	27.3	-	-	-	3	23.0	27.3
Trauma (10)	3	8.8	30.0	6	6.1	60.0	-	-	-	1	7.7	10.0
Female complaints (10)	3	8.8	30.0	5	5.1	50.0	1	6.7	10.0	1	7.7	10.0
Other (19)	5	14.7	26.3	11	11.1	57.9	3	20.0	15.8	-	-	-
Never sick (2)												
Totals	34	100.0		99	100.0		15	100.0		13	100.0	
% of Total (163)		20.9			60.7			9.2			8.0	

in actual therapy that women encounter. Thus, men express the wish to treat themselves, though in fact do not always succeed in so doing (perhaps partly due to wifely intervention). Table 45 clearly shows that women sought modern medicine in greater proportions than did men.

The reasons for choosing individual practitioners of medicine is shown in Table 45. Factors of convenience and availability of drugs were not articulated by informants during the survey although a number mentioned the points in informal discussion at other times, particularly in reference to seeking of modern medical treatment.

TABLE 45 REASONS FOR CHOICE OF PRACTITIONER

Reason for choice	Rural sample			Urban sample			Totals	
	women no.	%	men no.	women no.	%	men no.	total no.	%
Kinship	9	22.0	8	5	10.4	3	8	8.5
Friendship	1	2.4	-	1	2.1	3	4	4.3
Follower	-	-	1	-	-	-	-	-
Advice of friend	2	4.9	2	3	6.2	2	5	5.3
Healer well-known	2	4.9	3	10	20.8	13	23	24.4
Seeking modern medicine	14	34.2	7	24	50.0	17	41	43.6
Preferring self treatment	-	-	3	1	2.1	2	3	3.2
To be sure of cure (multiple choice)	6	14.6	-	2	4.2	3	5	5.3
No treatment	6	14.6	4	2	4.2	2	4	4.3
Never sick	1	2.4	-	-	-	1	1	1.1
Total	41	100.0	28	48	100.0	46	94	100.0
							163	100.0

The multiple reasons were given by those who had consulted more than one practitioner and, besides seeking modern medical therapy had also chosen another practitioner according to the first five choices in the table.

When practitioners visited the sick at home in order to treat them (and among the sample there were 23 rural and 9 urban visits to the sick in their homes), they were most often called by the kin and affines of the sick individual, as shown below. Some practitioners were living in the same house as the sick person, others knew via the village 'grapevine' and came by themselves, without being asked.

TABLE 46 SEEKER OF MEDICAL HELP IN CASES OF TREATMENT AT HOME: RURAL-URBAN COMPARISON

Seeker of medical help	Rural sample						Urban sample						Totals	
	women		men		total		women		men		total			
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Sick individual	2	15.4	2	20.0	4	17.4	-	-	-	-	-	-	4	12.5
Kin and affines	8	61.5	5	50.0	13	56.5	5	83.3	3	100.0	8	88.9	21	65.6
Friends	-	-	-	-	-	-	1	16.7	-	-	1	11.1	1	3.1
Healer in same house	1	7.7	1	10.0	2	8.7	-	-	-	-	-	-	2	6.3
Healer knew via 'grapevine'	2	15.4	2	20.0	4	17.4	-	-	-	-	-	-	4	12.5
Totals	13	100.0	10	100.0	23	100.0	6	100.0	3	100.0	9	100.0	32	100.0
% sample		31.7		35.7		33.3		12.5		6.5		9.6		19.6

A number of people - 16.6% - (27 altogether) were not satisfied with the treatment they had received during the episode of sickness under discussion; they were 11 rural women, 3 rural men, 10 urban women and 3 urban men. They had consulted a variety of practitioners - country,

modern medical and general and some had consulted more than one practitioner. One urban women and one man had both consulted a practitioner of modern medicine who had been unable to give them any treatment due to lack of drugs. Thirteen of these dissatisfied individuals had searched for other therapies before regarding themselves as cured. Four individuals considered that they were still suffering from their complaints some years later.

Question 42/64 enquired into how the practitioner had come to a decision about what was wrong with the informant. The majority of responses were to the effect that the practitioner either observed or examined his or her client in order to reach a diagnosis. However, a substantial number maintained that it was they themselves who informed their practitioner of the nature of their ailment, and this was the case with all types of practitioner.

TABLE 47 DIAGNOSTIC TECHNIQUE: RURAL-URBAN COMPARISON

Diagnostic technique	Rural sample						Urban sample						Total	
	women		men		total		women		men		total			
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Observation	10	24.2	6	21.4	16	23.2	17	35.4	11	23.9	28	29.7	44	27.0
Examination	5	12.2	5	17.9	10	14.5	22	45.8	23	50.0	45	47.9	55	33.7
Opening the book	1	2.3	3	10.7	4	5.8	4	8.3	4	8.7	8	8.5	12	7.4
Self-knowledge/ told practitioner	14	34.2	10	35.7	24	34.8	3	6.3	5	10.9	8	8.5	32	19.6
Multiple techniques	4	9.8	-	-	4	5.8	1	2.1	-	-	1	1.1	5	3.1
No diagnosis/ treatment	6	14.6	4	14.3	10	14.5	1	2.1	2	4.3	3	3.2	13	8.0
Never sick	1	2.4	-	-	1	1.4	-	-	1	2.2	1	1.1	2	1.2
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

6.3 THERAPEUTIC MILIEU

Questions 36 and 58 enquired into the place of treatment. The place where they receive treatment when sick is a matter of concern to the rural and urban people of Darfur. The majority of people would wish to be looked after by their kinfolk in their own homes, where someone will care for their smallest need and, if they wish to eat, they can eat the food they are used to and have it prepared especially for them. If it is necessary to become an in-patient in hospital or dispensary, in general, people quietly accept. However, they often leave suddenly and without warning, a few days before the time when the practitioner of modern medicine would have discharged them. (There is no worry about money, for medical treatment is free in Sudan.) Informants gave the impression that they did not like the unfamiliar surroundings in which they found themselves in hospital; the strange smells and sights, and the lack of privacy was very upsetting. Also, they do not like to be near the sick when they are themselves recovering.

Although the visiting times are elastic and usually several visitors are allowed in to the ward at one time in the easy-going rural hospitals, the patients feel uncomfortable when they are seen by other peoples' relatives. Quite often, when they are mobile, patients sit on the verandas of the wards or in the shade of trees and their visitors talk to them there. When they are talking about family and business matters, they do not wish to be overheard.

Anyone who also decides to continue taking some traditional medicine, such as mihaya, can easily take it during the visiting time, for visitors

often bring snacks with them and carry flasks which might contain a lemon or karkadeh drink, or indeed, miḥaya. If they wish, the patients' meals can be brought into the hospital, unless a special diet is required, so there is no problem over obtaining some form of traditional therapy while a patient is in hospital.

In general, people do not mind visiting the hospital, dispensary or dressing station to consult the practitioner of modern medicine, especially after their initial visit. However, they hardly ever go alone to consult the medical officer, medical assistant or nurse - husbands accompany wives, mothers and daughters or sisters go along together, brothers and male friends, sons and fathers accompany each other. In the case of an elderly person, several relatives may cluster around to give support and comfort. There is of course little in the way of transportation in these areas except for camels, donkeys and horses. Camels, particularly, are used if the sick person needs to be brought a distance on a bed. (The bed is strapped atop the camel's back, the sick individual is strapped to the bed.) Depending upon the nature of the complaint, the community health worker in the rural areas can easily visit a sick individual because some of his time is normally spent in visiting those who are not able to visit him.

In the villages of Jebel Marra it is quite common for healers to visit the sick in their homes, especially when they are related to them by ties of kinship or affiliation. Except in the busy part of the farming year, healers are not too busy to attend once or twice a day to their sick kinsman or woman. It is only in the urban situation where some healers,

especially those who are fully engaged in the healing arts, tend to remain in their treatment centres, and the sick come themselves to consult or are brought by their kinfolk. Such healers often have a house in their homestead where the sick person can remain for some days with a relative. If someone living nearby was sick, it is likely that the country practitioner would visit him or her at home.

Table 48 below, indicates where the informants interviewed who had suffered an episode of sickness, had been treated. Therapeutic milieux available to the Fūr are as follows: the home, where any practitioner may visit a sick individual, or where the sick person may treat himself or herself; the treatment centre, which could be the practitioner's own home or a separate establishment, such as a modern medical facility; or the individual might be treated in both types of therapeutic milieu.

TABLE 48 THERAPEUTIC MILIEU: RURAL-URBAN COMPARISON

Therapeutic milieu	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Treatment centre	14	34.2	7	25.0	21	30.4	38	79.2	38	82.6	76	80.8	97	59.
Treatment centre & at home	6	14.6	1	3.6	7	10.2	1	2.1	-	-	1	1.1	8	4.
Home	14	34.2	16	57.1	30	43.5	8	16.6	5	10.9	13	13.8	43	26.
No treatment	6	14.6	4	14.3	10	14.5	1	2.1	2	4.3	3	3.2	13	8.
Never sick	1	2.4	-	-	1	1.4	-	-	1	2.2	1	1.1	2	1.
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.

Besides pointing out the variations between rural and urban men and women in their choice of healer, and thus also place of treatment, the table indicates a changing attitude towards medicine and the therapeutic process. Urban practitioners of country medicine tend to operate more frequently from their own treatment centre, where the sick and their kin and friends gather, while waiting to consult the practitioner; it is not such a feasible proposition that the practitioner visit the sick - he is too busy. Practitioners of all types of country medicine are tending to adopt the ways of the modern medical practitioner.

6.4 THE CARING GROUP

Questions then enquired into who looked after (Q.33), or who was looking after (Q.55), the sick individual. Among rural people, the caring group consists almost entirely of the sick individual's kin and affines. This is mainly due to the fact that kin tend to live close to one another and also that whole village communities may be composed of an original central family and their near and distant kinsmen and women. In Barei there are few nuclear families where one partner is unrelated to one of the three main village families or where the married couple have moved to Barei from elsewhere. In such a community, one's friends and neighbours are also kinsmen. In an urban community, friends and neighbours may well be unrelated but it is not uncommon for them to take some part in caring for a sick person.

Children from a young age are included in the caring group by their mothers and fathers. They run errands from one household to another and fetch and carry within the homestead. Small girls, from about the age of seven years, make tea and the light nourishing drink, nisha for the sick person. They are left in charge of toddlers and to attend to the needs of the sick, while other family members carry on with the daily routine outside the village.

Table 49 shows the various members who make up a caring group. 'Friends and neighbours' is used as a category because this is how the Fūr spoke of them. They are generally fairly distantly related kinsmen, although urban friends and neighbours, in fact, may be related or unrelated.

TABLE 49 THE CARING GROUP: RURAL-URBAN COMPARISON

Caring group	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Kin + affines	40	97.6	26	92.8	66	95.5	41	85.4	32	69.5	73	77.7	139	85.
Kin + affines & friends & neighbours	-	-	-	-	-	-	4	8.3	1	2.2	5	5.3	5	3.
Kin + affines & modern medical practitioner	-	-	-	-	-	-	-	-	4	8.7	4	4.3	4	2.
Friends & neighbours	-	-	1	3.6	1	1.5	3	6.3	5	10.9	8	8.5	9	5.
Country & modern medical practitioner	-	-	1	3.6	1	1.5	-	-	-	-	-	-	1	0.
Modern medical practitioner	-	-	-	-	-	-	-	-	3	6.5	3	3.1	3	1.
Never sick	1	2.4	-	-	1	1.5	-	-	1	2.2	1	1.1	2	1.
Totals	42	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.

As can be seen from both the tables above it is unusual for anyone other than kin, to form the caring group among the Fūr. Those who cited a modern medical practitioner had not really been ill enough to require any sort of nursing care and attention, and had only consulted a modern medical practitioner in order to obtain drugs.

Even though the numbers are very small, urban people brought more categories of people into their caring group. A number also considered that the modern medical and country practitioner, whom they consulted were part of this group.

In rural and urban communities, if the sick individual is confined to bed, then he or she is attended for much of the day by a member of the caring group. If he or she is able to get up and move around, the caring group is likely to decrease during the day to one or more young children, usually girls.

The caring group usually consists of a woman - wife, daughter, mother or sister - who cooks food specially for the sick individual and a person of the same sex who attends to personal needs if necessary. This member of the group is usually a young person, a teenager or one in the early twenties, usually unmarried. As mentioned earlier, the small children also play their part. If the sick person is an elderly grandparent or head of a large and important family, for example, then the caring group is larger than that for a younger individual of a lesser social standing.

When visits are made to a modern medical treatment centre of any kind, a close male relative quite often takes the leading role in the caring group and talks to the practitioner, giving the history of the case and answering questions. Medical officers and medical assistants say that they

often experience difficulty in obtaining a patient's own replies to questions about the condition. People in Darfur are generally accustomed to 'handing over' their ailments to a healer with the statement 'I am ill' or 'my whole body/my skin is paining me'. With such a statement of symptomatology, the practitioner of country medicine will set about 'opening the book' as a prelude to making miḥaya, but this is not considered enough by the practitioner of modern medicine to begin to make a diagnosis, let alone to treat, and time must be spent in eliciting a history and symptoms. In such instances, the accompanying relative, who is neither suffering the ailment nor the distress of perhaps visiting the hospital for the first time, is an invaluable informant.

Husbands usually accompany their young wives to consult the practitioner of modern medicine, but an older married woman might be accompanied by her sister or friend, or other kinswoman, or even by a child. Old women are often brought by their sons, with or without a female relative. Men usually accompany men of all ages. Children may be brought by either parent or by both if they are babies, or sometimes by a grandmother.

6.5 VISITORS TO THE SICK

Questions 34/56 and 35/57 enquired into visitors to the sick; if they received visitors and, if so, who were they.

When an individual is sick in Darfur, many people - kin and affines, friends, neighbours and others who feel concern - go to the house where he or she is staying, especially if the sickness is thought to be serious. Visitors of the same sex cluster around the bed or where the person is

sitting. Close kin of the opposite sex may also visit, but others will join other family members outside the room where the sick person is; men tend to gather under the shade roof, women in the area of the kitchen. All visitors are given tea and possibly a cool drink of lemon or karkadeh, made by a young girl who is assigned to attend to the guests.

Most visitors have their own ideas about the diagnosis and stories of others who have been similarly ill, and who might even have died. All this information is exchanged over the sick person. Some may even offer advice about treatment. If the person is able to join in the conversation, he or she may do so but in any case, the scene is likely to be quite a noisy one.

While the individual is seriously ill, visitors come in numbers but when recovery becomes obvious, fewer visitors come each day, perhaps because they realize that the danger is over. Those who are not so seriously ill do not as a rule receive many visitors and their condition may only be known to their immediate family.

TABLE 50 VISITORS TO THE SICK: RURAL-URBAN COMPARISON

Visitors	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Kin + affines	25	61.0	13	41.3	38	55.1	12	25.0	12	26.1	24	25.5	62	38.
Kin + affines & non-kin	7	17.1	7	25.0	14	20.3	25	52.1	22	47.8	47	50.0	61	37.
Non-kin	3	7.3	2	7.2	5	7.2	10	20.8	7	15.2	17	18.1	22	13.
No visitors	5	12.2	6	21.5	11	15.9	1	2.1	4	8.7	5	5.3	16	9.
Never sick	1	2.4	-	-	1	1.5	-	-	1	2.2	1	1.1	2	1.
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.

Urban dwellers tend to have more visits from people with whom they have no relationship than do villagers. This may be partly because there are fewer of their kin and affines living in close proximity but also because they have a wider circle of friends and acquaintances.

6.6 ESTIMATION OF INCAPACITY AND SEVERITY OF SICKNESS

Questions 24/46 and 40/62 enquired into incapacity caused by the sickness and the severity of the sickness, as estimated by the sufferer. Relatively few individuals of those chosen at random for interview, were sick at the time of the interview. Those who said they were sick were not incapacitated to any great extent. Sick individuals suffering any severely incapacitating condition, were only encountered in hospital or while they were consulting a modern medical practitioner or attending a traditional healer. During the time in Barei only one man, the elderly shaykh, was moderately incapacitated. In Azumiya one woman had just returned from hospital, one man was chronically and seriously incapacitated from a road traffic accident some years previously and another man had been severely handicapped from childhood, most likely as a result of poliomyelitis. The majority of individuals who considered themselves to be sick at the time of interview, were not seriously incapacitated, and were suffering from headache, malaria, stomach ache, and digestive disorders, menstrual discomfort, and pregnancy related problems.

In order to estimate the incapacity they suffered during the episode of sickness under discussion, informants were asked to place their incapacity on a scale of 1 - 4, (from being able to carry on with the

normal round of daily life to being up but not active, preferring to remain in bed, and being unable to rise from the bed unaided, at the time when the sickness was at its worst). As can be seen from the table below, just over half of the sample said that they had not been able to carry out their normal daily routine activities during their episode of sickness.

TABLE 51 ESTIMATION OF INCAPACITY: RURAL-URBAN COMPARISON

Estimate of incapacity	Rural sample						Urban sample						Total	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Unable to rise from bed	19	46.3	12	42.9	31	45.0	8	16.7	5	10.4	13	13.8	44	27.0
able to get up but in bed	9	22.0	2	7.1	11	15.9	13	27.1	9	19.6	22	23.4	33	20.5
up but not active	3	7.3	3	10.7	6	8.7	9	18.7	3	4.3	12	12.7	18	11.0
Total unable to function normally	-	-	-	-	48	69.6	-	-	-	-	47	50.0	95	58.3
Able to function normally	9	22.0	11	39.3	20	29.0	18	37.5	28	60.9	46	49.0	66	40.5
Never sick	1	2.4	-	-	1	1.4	-	-	1	2.1	1	1.1	2	1.2
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

The difference in estimation of incapacity seen in the two samples of the population of the communities studied, is perhaps related to effectiveness of treatment. Among the urban sample, treatment was most likely to have been started before too much incapacity had resulted. Many

of common conditions such as fevers, digestive disturbances and respiratory conditions, are eminently suited to drug therapy and the people are aware of this. Thus, at the first signs of the sickness, they consult a modern medical practitioner and receive suitable drugs to combat the symptoms. Rural people, not having the same facilities, are used to attempting to continue with their daily activities until they either recover or become quite seriously ill.

In a subjective estimation of severity of the episode of sickness (on a scale from trivial to serious and very serious/almost fatal), the majority of people considered - as might be expected - that they had been seriously ill. In particular, few rural people considered their sicknesses had been trivial. Even when they had been able to continue with activities, some people regarded their sickness as very serious, particularly if it had been of long duration or they had suffered intermittently from what they considered to be the same sickness. A sickness which is difficult to explain is usually regarded as very serious, even when it is minimally incapacitating.

TABLE 52 PERSONAL ESTIMATION OF SEVERITY: RURAL-URBAN COMPARISON

Estimate of in- capacity	Rural sample						Urban sample						Totals	
	women		men		total		women		men		total			
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Trivial	6	14.6	5	17.9	11	15.9	10	20.8	17	37.0	27	28.7	38	23.3
Serious	21	51.2	12	42.9	33	47.8	24	50.0	19	41.3	43	45.7	76	46.7
Very serious	13	31.7	11	39.3	24	34.8	14	29.2	9	19.5	23	24.5	47	28.8
Never sick	1	2.4	-	-	1	1.5	-	-	1	2.2	1	1.1	2	1.2
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

6.7 PAYMENT FOR TREATMENT

Questions 38/60 and 39/61 enquired into payment for treatment: if payment was made and, if so, to whom. Throughout Sudan, modern medical drugs and medical care are free, unless the practitioner of modern medicine is consulted privately. Practitioners of country medicine are, however, often paid for their treatments, although many feqis receive only a very small but traditional token payment called a bayaḍ.¹ This bayaḍ is usually in the form of money in urban areas and during the time of field-work, was usually 25 piastres² in Zalingie and the Western District. Sometimes in the rural areas, a small amount of sugar or tea is used instead.

The bayaḍ is in the nature of a down-payment; the client shows his appreciation of the feqi's part in his recovery by making a further presentation, of money or some other gift, when he is well, if he can afford to do so. Usually, neither the bayaḍ nor its complement is actually presented to the feqi, unless he is alone, when the bayaḍ may be slipped under an object near to the feqi. There is no acknowledgement by the feqi of the presentation of the bayaḍ. If one of the feqi's pupils is with him, or his son then the bayaḍ is usually given into the safe-keeping of this person. A feqi regards himself as an instrument used by God to channel his healing power. Thus, the feqi could not receive a straightforward payment. Although there should be a complementary presentation following the bayaḍ in the traditional form of payment, it would appear from information gathered from both feqis and clients, that this does not always materialize, or at least it often takes a considerable time in arriving.

1. bayaḍ (Ar.) = whiteness, openness, purity. See also Chapter 7.

2. Equivalent to about 12½p. at the time.

TABLE 53 PAYMENT FOR TREATMENT: RURAL-URBAN COMPARISON

Type of payment	Rural sample						Urban sample						Totals	
	women no.	%	men no.	%	total no.	%	women no.	%	men no.	%	total no.	%		
Cash	5	12.2	1	3.6	6	8.7	2	4.2	4	8.8	6	6.4	12	7.4
Traditional:														
<u>bayad</u>	1	2.4	-	-	1	1.5	3	6.3	2	4.3	5	5.3	6	3.7
<u>bayad</u> + kind	-	-	-	-	-	-	2	4.2	2	4.3	4	4.3	4	2.4
kind	3	7.3	2	7.1	5	7.2	-	-	-	-	-	-	5	3.1
Multiple:														
Cash & kind + traditional payments	4	9.8	1	3.6	5	7.2	-	-	2	4.3	2	2.1	7	4.3
No payment	21	51.3	20	71.4	41	59.4	39	81.2	33	71.8	72	76.5	113	69.3
Never sick	1	2.4	-	-	1	1.5	-	-	1	2.2	1	1.1	2	1.2
No treatment	6	14.6	4	14.3	10	14.5	1	2.1	2	4.3	4	4.3	14	8.6
Totals	41	100.0	28	100.0	69	100.0	48	100.0	46	100.0	94	100.0	163	100.0

It is not uncommon to give a bayad only, and in urban areas it may be much more than 25 piastres. However, there is often a gift of cloth or perfume or foodstuff made in the urban area by those who can afford to and by rural women. Rural men often given firewood or soap, sugar or tea as their full payment but this does not usually occur in the urban setting. The difference in style of payment between rural and urban people may be due to the fact that the rural healer is so often a kinsman and the relationship less formal than between an urban healer and client.

6.8 PRACTITIONER CONSULTATIONS

During the course of fieldwork, many practitioner consultations were witnessed. The following accounts illustrate a number of points which typify the conduct of such consultations.

6.8.1 Consulting a practitioner of modern medicine

The people wishing to see the community health worker usually gather at the dressing station in Daiya early in the morning and when the orderly opens the door, the women enter the small building and sit on benches inside; the men wait outside under a shade tree or at the side of the building. The community health worker arrives, greets everyone and starts his work. When a new patient comes for treatment, accompanied or otherwise (for here almost everyone knows the health worker or is related to him), he or she is asked about the condition troubling him/her. The usual answer to the question 'What is wrong with you?' is 'I am ill', or literally, 'The body is paining me' ('sor gi wey'). Further symptomatology can usually only be elicited by several more questions such as, 'Do you have pain?' and 'Please show me where the pain is'. In this way, the practitioner of modern medicine can slowly learn of the problem. He then decides what treatment he can give, whether in oral form, or as an injection or by a local application. The treatment is given and the patient instructed when to attend for further therapy and assessment of the condition.

The whole process of treatment by the community health worker is studied intently by all the women present in the dressing station awaiting treatment, there is no privacy; the complaint, the diagnosis of the health

worker (if made known to the patient) and the treatment are all known to everyone attending. However, there would hardly ever be an occasion where privacy for the patient was necessitated for practical purposes, for the complaints which the health worker is qualified to treat are limited to the common and less serious. Others should be referred to the medical assistant.

The following account is of Adam, a middle-aged farmer, who decided to consult his sister's son who was a community health worker. This was his first visit to a practitioner of modern medicine. He had been suffering from abdominal discomfort and diarrhoea for almost two days and met his young kinsman by chance the previous evening while returning from market and feeling very unwell. The young man suggested that Adam should visit him at the small dressing station the next morning.

Adam arrived early at the dressing station on his donkey, he had come several kilometres and was eager to get back to his farm. However, he had to wait while the community health worker finished treating the last two women remaining inside. The last woman left with her children and Adam entered the tiny cottage which formed the dressing station. He sat down on the bed and pulled up his sleeve, expecting that he would be given the injection he had heard about. The community health worker explained that he was not to be treated by injection but with the white medicine, which he was offering in a small cup. Adam seemed rather disappointed but drank the medicine. He was then instructed to drink plenty of tea and karkadeh for the next day or two and to send his small son with a container for more medicine for the evening and to report again the following morning. He asked once more about injections but was reassured and left.

Adam's small son duly arrived some time later to collect the evening dose of medicine and Adam himself returned the following morning stating that he felt very much better. He took his medicine and was about to depart when he turned back and again asked if he could not have an injection, 'just to be sure'. This seemed to have become a joke for then everyone present - community health worker, orderly, the midwife and Adam - all laughed as he went on his way.

When consulting the medical officer or medical assistant in his hospital clinic, the patient is more likely to be accompanied. Patient and kinsman or kinswoman enter the clinic rather shyly, unless the kinsman has attended before or knows the medical practitioner. The patient in this case is often very shy or frightened, particularly if the medical practitioner is a foreigner to Darfur (i.e. from another part of Northern Sudan), which is likely. Here the accompanying relative assists with the interviewing of the patient, who may not speak Arabic and therefore cannot fully communicate his or her symptoms in any case. The problem of language combined with the reluctance of the Fūr to be explicit about their complaints, can lead to some misunderstandings on occasion. The patient is usually left silently standing before the desk of the medical practitioner, quite bewildered.

A request by the doctor to carry out examinations on Fūr women is usually met with docile compliance. (However, some rural Arab women refuse at first and may leave the clinic amidst a state of some confusion. Often, though, a nurse's calming influence can rectify this situation.)

Consultations with doctors and medical assistants are held in some privacy, except for the nurse and orderly in attendance, although this is

hardly noticed by the patients as they are generally distracted by nervousness. Consultations with these modern medical practitioners usually last some few minutes only and leave the sick person looking somewhat bewildered and wondering why they have been asked so many questions about themselves - concerning feelings which they are not used to articulating. Some people expect that el-daktūr should take an X-ray to see what is wrong with them instead of asking questions. This was compared with the feqi's 'opening of the book' by some informants.

When given their treatment, whether it is an injection (which is the preferred therapy) or other drugs, the Fūr usually listen to instructions and continue on their way, in contrast to most Arab patients who, having been more loquacious concerning their symptoms, are also very inquisitive regarding their therapy and any dietary habits which they may adapt to aid healing. This was noted by a number of modern medical practitioners.

This account is of a woman in her early forties named Keltoum, the mother of six children, a farmer and housewife. Keltoum walked rather nervously into the office of the practitioner of modern medicine behind her husband a government employee. She sat down beside the desk, looking distinctly unwell and feverish. Her husband stood at the other corner of the desk and started to talk to the practitioner. Keltoum had felt ill for about two days now and although the fever was less, she was not improving as he had expected and was now complaining of lower abdominal discomfort. She was possibly two or three months pregnant.

The practitioner of modern medicine asked Keltoum to describe her symptoms but she seemed unable to do so, only repeating that she was ill,

her body was paining her. The practitioner spoke again to Keltoum's husband, and asked if he would take her across to the private ward now as she must be admitted immediately. Keltoum was most likely suffering an abortion, caused by her high fever. He would need to examine her and carry out a minor operation¹ to remove the foetus.

Keltoum managed to get up with her husband's and a nurse's help and walked slowly out of the office. During the entire consultation she had hardly spoken; the whole interview was conducted for her by her husband. (This was not only because the sick woman was too ill to speak; other women whom I witnessed attending the various treatment centres of modern medical practitioners who agreed to be informants, acted in a similar way.)

Two days later Keltoum was sitting on the side of her hospital bed looking much better, when I went to visit her. Three of her daughters and youngest son were also sitting on the bed. She offered me karkadeh from a flask, and sweets. She felt fairly fit again but was sad to have lost the baby, which she attributed to the nivaquine she had taken for the malāriya. She was happy to be going home that afternoon and insisted that I should visit her at home.

6.8.2 Consulting a practitioner of country medicine

When it has been decided that a practitioner of country medicine should be consulted and the sick individual is to visit him, he or she will probably go along to the practitioner accompanied by a male relative. If a woman is sick, it may be that her mother or aunt may accompany her on follow-up

1. Keltoum's operation was that of dilation and curettage (a D and C) performed under general anaesthesia, the normal modern medical treatment in cases of early abortion.

visits, or even small children. However, if the practitioner is related, lives in the same neighbourhood or village or close-by and the sickness is not too incapacitating, the person may go alone. As already mentioned, urban practitioners often play a full-time healing role, while their rural counterparts may only practise when called upon to do so. The full-time practitioners are more likely to have some sort of treatment centre with a designated waiting area in their homestead, where clients and their relatives can sit before the consultation. People seeking help from rural practitioners may know when they are at home by familiarity with their everyday routine, and may visit them at a convenient time, or they may know other members of the household and pass the time with them.

The following account is of the visit of Hawa, (a 30-year old married woman) to an urban practitioner,¹ a feqi whom she had visited a number of times previously for different complaints. This time she came to the feqi with one of her daughters (she has six children, the youngest was three years old at the time).

Hawa entered the sheltered reception area or rakūba of the feqi which was used as his treatment centre, having left her shoes at the door, and sat down on the rush mat to the left of the wooden bed on which the feqi himself was seated. Her little daughter of eight years sat next door to her. She greeted the feqi reverently and he returned the greeting, also asking her how she was feeling. Hawa complained of not feeling well but did not elaborate upon this point. The feqi invited her to drink miḥaya

1. The visit to a rural healer would be a simpler version of the one described here, but essentially similar.

from the vessel in the centre of the floor and she took a cup of the grey-blue liquid and then gave some to her daughter. The feqi then began to diagnose Hawa's problem by consultation of his rosary¹ - a method he preferred to the usual one of 'opening the book'.

After reaching some conclusion about diagnosis and the suitable therapy, the feqi proceeded to take a strip of paper cut from a foolscap sheet. Resting on his loh,² he divided the strip into seven and in each section wrote a verse from the Qur'an. He then tore each section off and folded it, thus making seven bukharat, each of which Hawa was instructed to burn on charcoal with bukhūr, inhaling the resultant smoke. This, she was to do each evening for a week. On receipt of the bukharat, Hawa placed her bayaḍ under a book near the feqi.

The feqi then took up his rosary again and began to perform Ḍazīma for Hawa, occasionally blowing the words in her direction. He intoned the verses of the Ḍazīma in a low indistinct voice which no-one could interpret. He continued in this manner for almost half an hour, Hawa just remained sitting quietly on the mat. During this time there were two interruptions when a woman of the feqi's family came to ask a question on behalf of another woman and when an old friend of the feqi arrived from afar. However, the feqi, apart from answering the question and greeting his friend, carried on with his performance of Ḍazīma.

When he had finished the performance of Ḍazīma, the feqi took Hawa's right hand and wrote some words from the Qur'an on the palm using the pen and ink with which he normally writes on his loh. He then instructed her

1. Consultation of rosary - a method of determining the correct verse in the Qur'an, to be used in therapy - see Chapter 7, 7.7.2.

2. loh - wooden board used for writing by feqis and muhajarīn.

to lick off the verse, which she did. This concluded the treatment session. She was reminded about the bukharat by the feqi and then got up to depart, taking her leave of the old man. Hawa and her daughter left the treatment centre collecting their shoes and bidding the feqi's family farewell on the way out.

During the half-hour of Hawa's therapy a number of people entered the feqi's rakūba, mainly men but also another woman and two girls. Some of these people were seeking treatment, two of the men were students of the feqi. They appeared to take no notice of Hawa and she showed no sign of embarrassment; it was as if healer and client were isolated from their surroundings, which became quite noisy with greetings among the men assembled in the corner furthest from the healer. However, as soon as the therapy was completed and Hawa got up to depart, there was a silence as the group was now again in the presence of the venerable feqi.

This was Hawa's first visit to the feqi for the complaint then troubling her, though she had consulted the feqi on previous occasions. On the first occasion her husband (a follower of the feqi) had accompanied her, she informed me when I talked with her a few days after the visit to the healer. Thus, it was not unusual that she was accompanied by her daughter on this occasion even though the little girl was only eight years old; it would not have been correct for her to have gone alone.

The diagnosis, though not by the usual method employed by the majority of feqis, was nevertheless, by mystical means - the rosary being used to select the verse of the Qur'an which would bring relief. This particular feqi has such a knowledge of the Book that he has no need to check the

reference; 'it is in his head' according to one of his sons-in-law. Thus, he is a much respected man because of his knowledge of the Qur'an and he also has a reputation for his healing powers and numerous people encountered had received treatment from him and been cured.

The treatment given to Hawa involved four different methods of using the holy word therapeutically - inhalation of fumes of the burning of bukharat, performance of ʿazīma, drinking of miḥaya and licking of the words from her own hand. The therapeutic session lasted for half an hour, during which time the feqi's attention was concentrated upon his client.

Although other people (mainly men) entered the treatment centre they sat down and quietly talked among themselves and the consultation and treatment continued as if nothing had happened. Healer and client were somehow separated from the goings on around them. When answering the questions from outside the immediate therapeutic milieu, the feqi's attention hardly wavered from his client and immediately the question was answered, he continued from where he had left off. Thus, one felt that the treatment was entirely a private affair between practitioner and client and Hawa confirmed this later.

During the treatment session, the traditional payment by bayaḍ was made. This was the usual small offering, a 25pt. note and was not given to the feqi but slipped under the book he had left lying on the floor, probably for this very purpose. As this woman's husband was a regular student of the feqi and was relatively well-off, a more substantial payment, probably in kind rather than cash, would be made at a later date.

Perhaps the most important point to make about this treatment session is that the client said that she went away with a feeling of satisfaction that she had received expert treatment from someone who had spent time with her. He had also given her part of her treatment to take home, where she could carry out the prescribed routine herself, over the next week. However, despite all the concern regarding his client's complaint, the fegi did not ask her what her symptoms were and she did not attempt to tell him. Hawa was quite confident that the fegi knew exactly what she was suffering and he had given her a specific treatment for her symptoms.

During this interview Hawa was asked about her sickness and the treatment she had received. She had in fact first consulted a modern medical practitioner whom she normally consulted for herself and for her children, and had been given some tablets. She felt this had not cured her and she was suffering the same abdominal pains, which had troubled her on and off (irregularly) for the past eight years. Hawa believed that these pains had something to do with the eating of marāra (the raw liver, lungs and stomach of a sheep which have been marinated in lemon and onion for a short time) with much hot red pepper. However, she also ascribed her sickness to the evil eye, which, she said had affected her and her children at the wedding of her husband's sister. She could give no more information than this.

Having first tried modern medicine, Hawa decided to visit her husband's mentor and was quite satisfied with the attention she had received and the treatment given. She was using the bukharat as prescribed

and felt certain that she would be cured. When visited several months later, Hawa was feeling well and had not suffered the abdominal pains since her treatment.

6.8.3 Consulting a General Practitioner

Consultation of a general practitioner most frequently takes place in the sick person's own home although, in an urban area, it could also take place in the practitioner's treatment centre. The following account is of the consultation of a general practitioner by Abd el-Hāmid, a Fūr farmer and citrus grove owner, whose son had sustained an injury to his ankle when he fell off a donkey two months previously (the timing of the injury may well not be accurate, however). This boy was about seven years old and had been treated already by his father, using a decoction of the bark of the tree, kurul (Acacia albida, L.) and Cazīma. The injury had not healed and by this time had a continuous foul-smelling discharge.

The general practitioner whom Abd el-Hāmid approached was a friend of his, a merchant who travelled between many Jebel markets taking orders and delivering goods to merchants and buying millet for sale in the larger markets of Nyala and el-Fasher. He always carried with him his black bag containing a variety of modern medical drugs, the box containing his syringe and needles and sometimes also some roots. The drugs he had on this occasion were penicillin for injection, tetracycline capsules, Librium, vitamin tablets and a number of anti-diarrhoeal and worm preparations.

The practitioner arrived at Abd el-Hāmid's home and was welcomed by all who were there, for Abd el-Hāmid had himself received an injection from this

man and was well pleased with his recovery. Abd al-Hāmid's brother was visiting and his wife's parents were also at home to greet the practitioner, who paid attention to the children, especially the boy he was to treat. The men then sat down and tea was brought by one of the other children. When they were refreshed the practitioner asked Abd el-Hāmid to boil the box containing his syringe and this was duly dispatched to the kitchen. Abd el-Hāmid collected it some time later and the practitioner assembled the syringe and needle and expelled the remaining water. He opened a phial of injection water and drew it up into the syringe, adjusted the amount and inserted the needle into an ampoule of penicillin powder, removed the syringe and shook the ampoule to mix the solution. He then drew up the injectable solution, expelled the excess and walked into the cottage where the boy was waiting with his mother. The practitioner lifted the loose sleeve of the boy's jellabiya, pinched the deltoid muscle just below the shoulder and administered his injection. The boy winced but did not speak and the treatment was over.

The practitioner collected his belongings, washed out his syringe, returned it to its box and put this into his bag, promising to return the following week to see how the boy was doing.

I do not know how this boy fared because I was only visiting this village and left later that day. However, his wound looked and smelled as if he was suffering what practitioners of modern medicine would term osteomyelitis, a chronic condition involving bony tissue, necessitating lengthy modern medical treatment, usually surgery and the use of antibiotics.

6.8.4 Comparison of practitioner consultations

In the accounts above, all the practitioners were known to their clients or to the client's kinfolk. This, all clients felt, was reassuring, as was their familiarity with surroundings. Rural individuals seeking treatment from a nurse or community health worker are usually familiar with the small cottage dressing station and with the locally made furniture inside. The small stock of drugs and limited amount of instruments does not detract from the basically friendly atmosphere of such a treatment centre where most of the clients know each other. The bigger treatment centres, dispensaries and hospitals do not have such a friendly atmosphere, partly because people tend not to know each other but also because of the size of the establishment, the fact that many employees wear a uniform, which is a distancing factor as well as distinguishing, and because of the regimentation of the sick, a necessary feature of any large treatment centre.

When the sick person goes into the office of the practitioner of modern medicine, he or she is confronted by the practitioner behind a large desk, attended by a nurse and an orderly. Around the room can be seen a variety of instruments and a screened off area (for examinations), to where the sick individual may be directed to have an examination, to which they might prefer not to submit. The practitioner of modern medicine, whether medical officer or medical assistant, may well not be a Darfurian, and thus a 'foreigner' as well as a stranger to his client. Darfurians tend to think of people from distant Khartoum (1500 km. away) as foreigners because their way of life has many differences.

Informants felt that the short interview-examination time spent with a sick individual was a disadvantage and compared poorly with that which a

practitioner of country medicine might offer. However, the treatment by general practitioners, particularly by those who give injections, may also be very brief. The main difference here being that this practitioner does not spend time asking questions of the sick individual, which he or she might well feel unable to respond to, having not articulated fears and feelings previously.

The practitioner of country medicine, besides being a familiar person in his or her own locality, is probably related by kinship and affinal ties to many people living in the area. In the rural and urban areas the majority of practitioners of country medicine establish their treatment centre within their own homestead. This would be a familiar setting as it would be similar to the homesteads of that area. Most people too, have visited a feki at some time in their lives, if not other practitioners, accompanying a kinsman or friend. Children accompany their mothers and older sisters when visiting for a consultation or to collect an amulet.

When practitioners of country medicine are working as full-time healers they give the impression of having time for everyone at almost any time of the day. There is no rush and no time limit. Those who are part-time practitioners give time when they are free and their patterns of work are probably known to their clients. From discussion with informants and the many consultations I witnessed, it seems that time is no object if a client has need of the practitioner's time. The atmosphere, particularly in a feki's treatment centre, is relaxed and each individual would appear to be individually prescribed for. The client is also frequently given a portion of the treatment to take home, thus taking an active part in his or her own recovery.

The general practitioner fits into the picture between the modern and country practitioners. His therapeutic regime often consists of at least two types of healing techniques, combining modern medical drugs with some form of country medicine such as roots. As mentioned above, his actual consultation time is usually brief, although the welcoming to the homestead and entertaining prior to treatment of the client may be seen as part of the consultation. Modern medical drug administration in the form of an injection is a much desired form of therapy and doubtless, with the lack of awkward enquiry into symptoms, is suitable recompense for the brevity of consultation. Other advantages of choosing this type of practitioner are that he is certain to be carrying modern medical drugs with him and that he will treat people in their own homes.

Thus, it would seem that all practitioners have positive features as far as the Fūr are concerned, though perhaps none has all the qualities they might hope for. Nevertheless, the general practitioner of medicine probably embodies most of the sought-after features, though practitioners of this type are few and far between.

6.9 SUMMARY

Data collection using the survey questionnaire, supported by participant observation, indicates a definite preference by the Fūr for modern medical drug therapy, both for themselves and for their children; it is not necessary, however, that the drugs be administered by a practitioner of modern medicine, although this usually is the case. Many people are still in two minds about modern medicine. They appreciate the drug

therapy but are not so enamoured of, what appears to be to them, a lack of sensitivity and caring on the part of the practitioner, although no-one expressed this sentiment quite so explicitly. For the caring aspect of the therapeutic process, people like to consult a feqi, for he is certain to give them time, a sympathetic ear and the attention they need. The 'other-worldliness' attributed to feqis - their bridging-link with God - is assumed to open up a pathway for healing power. Among rural people, however, there was more consultation of practitioners of country medicine. The difference in rural and urban practitioner-consultation is, at least partly, due to availability and obtainability of modern medical drugs. Kinship may also play a part. However, even if the practitioner of modern medicine is a kinsman, if he has no drugs then he and his branch of medicine may be regarded as incompetent. It seems then that the data gathered among the Fūr are somewhat ambiguous over choice of practitioner and therapy. The type of cause of sickness has little bearing on practitioner choice and also the type of sickness does not appear to greatly influence the choice of therapy. There is though, generally, a marked preference for and actual choice of modern medical therapy, (which is usually dispensed by practitioners of modern medicine) in the urban area and a less marked preference and actual choice in the rural area. Those individuals who claim not to know the cause of their sickness also show a preference for treatment by the modern medical practitioner. However, despite this preference for modern medicine, country practitioners continue to be consulted, though to a lesser extent than before the advent of modern medicine.

Most people would prefer to be treated at home when sick but must usually attend a treatment centre, although in the rural areas most practitioners are able and willing to make home visits. Some individuals treat themselves at home. People tend to be eager to return to their normal daily activities following sickness; malingering seems to be virtually unknown in Darfur, a fact emphasized by the numbers of those who continue to work in the fields despite their infirmities.

Modern medicine is free in Sudan but practitioners of country medicine charge for their services, either in the form of money or as a traditional payment, a bayaq, with a follow-up payment when the sufferer is well again. People are not always happy about not paying for their medical treatment and attempt to give the 'foreign' modern medical practitioners a small prestation before their treatment commences. This is not always understood and the prestation is misconstrued as a bribe by those for whom the state system is customary and familiar. Where no relationship already exists, what appears to be a gift (free medical consultation and drugs) on first encounter, places the receiver in an embarrassing position. Realizing what is about to happen, the individual attempts to make the initial prestation. As Mauss points out, 'The gift not yet repaid debases the man who accepts it, particularly if he did so without the thought of return', (Mauss, 1954:63).

The next chapter now looks closely at the various practitioners of medicine to be found in Darfur and the therapeutic techniques they employ.

Chapter 7

THE PRACTICE OF MEDICINE

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7.1 INTRODUCTION

There is an extensive network of practitioners of medicine in Darfur (a list of those interviewed during fieldwork is shown on the following page). Many practitioners in urban areas work in treatment centres and are fully employed in the field of medicine. Those who are part-timers may be government employees or skilled workers, merchants or farmers. On the other hand, in the rural areas, most practitioners are farmers and fulfil their healing role only when called upon to do so.

Home therapists and feqis are the most numerous practitioners of medicine, to be found in every community - almost in every hamlet. Practitioners of modern medicine are also fairly numerous, but tend to be clustered in large treatment centres, subjected to the hierarchy of the modern medical profession. Relatively few of them are working in the community. The primary health care complex (see Chapter 9) covers a large area with few practitioners, necessitating journeys of up to ten miles for the sick in some cases.

Practitioners of medicine are portrayed in this chapter with a few short biographical sketches of each type of practitioner to illustrate their various careers. The biographies are followed by accounts of their prophylactic and therapeutic techniques. An attempt is made to analyse the Fūr view of a selection of the great range of their therapies and prophylactic measures. However, due to the secrecy of the country practitioners regarding their materia medica, the linguistic difficulties

encountered in naming most of the medicines and the limitation of time, the obtaining of data on what is used as medicine and the reason behind the use is not as detailed as one might have wished. There is in Darfur a wealth of information to be collected concerning country medicine, particularly that of the herbalist, the owner of roots.

The following table indicates the wide variety of practitioners of medicine to be found in Darfur.

TABLE 54 PRACTITIONERS OF MEDICINE WHO ACTED AS INFORMANTS IN DARFUR¹

35	<u>feqis</u>
1	<u>shaykh</u>
1	<u>goni</u>
4	spirit healers
2	diviners
6	herbalists
7	home therapists
3	general practitioners
4	bone-setters
2	rope-midwives
1	eye practitioner
8	general medical officers (MB.BS.)
4	consultant physicians and surgeons
1	deputy assistant commissioner for health
2	pharmacists
1	superintendent of medical assistants
7	medical assistants
4	nurses (Sudan registered nurse)
4	midwives
3	community health workers
1	public health officer

1. Most practitioners were formally interviewed, but a few gave 'on the spot' information.

7.2 THE FEQI

The feqi¹ is perhaps the most important and renowned healer in Darfur. Feqis from Darfur particularly those from Kongyo, west of Zalingie, are also famous throughout northern Sudan and are credited with an abundance of mystical power, enabling them not only to heal but to have power over objects, to be able to transport themselves great distances (with no physical means) almost instantaneously and to transmogrify (leopards and jackals being the usual animals chosen for this metamorphosis).

After his years as a muhajir, at first wandering from one teacher to another and then under the tuition of one who is learned in techniques of healing, the student begins to receive instruction regarding the therapeutic and prophylactic use of techniques derived from the Qur'an and from the writings of early mystics who mixed religion with Arabic medicine and magic. When his teacher thinks he is ready, the feqi leaves to set up his own healing practice, quite often in conjunction with a Qur'an school. Perhaps it should be noted here that there is a very great range of abilities found among feqis in Darfur, regarding their recitative and intellectual knowledge of the Qur'an.

A feqi is consulted by both men and women, for physical and emotional problems. Much of his time is spent dealing with problems which would be referred to a psychiatrist or counsellor in modern medical practice. He frequently uses techniques of treatment borrowed from other country medical specialists and amalgamates them with his own therapies. Roots and a number of modern medical drugs are added to miḥaya sometimes and certain feqis also engage in the surgical techniques of the blacksmith, cautery, cupping and cutting.

1. See appendix 2 for further information regarding the feqi and his part in history, his wandering apprenticeship and the teaching aspect of his role in a Fur community.

As a rule feqi do not ask for any payment for any therapeutic or prophylactic procedure they carry out but it is traditional to offer a bayad as a small prestation before the performance of any therapeutic or prophylactic measures. Such a bayad may be as little as 25 piastres (approximately equivalent to 12½ pence), although this may be overlooked if the client is too poor. The completion of payment to the feqi is made when a sick individual has recovered or when a prophylactic hejāb (amulet) is collected. Both bayad and further payment may be in kind, especially if the feqi is related to his client.

When he is available for consultation, the feqi is usually to be found in his rakūba¹ unless he has a brick-built house, which is not common among Darfur feqis. However, a few feqis were encountered who did have brick-built houses but their consulting rooms (except in one case) were still rakūbas built near to the gateway of the homestead. In the rural areas, especially during the busy farming season, the majority of feqis have to work on their farms and are only to be found at home after nightfall. Urban feqis are more often full-time healers and teachers, although their wives may be farmers. A few urban feqis had no other visible means of support than the payments of clients. Those who have a reputation as healers often are consulted by people from afar and have a small house in which a sick person and the accompanying relative may stay for a few days.

The homestead of a feqi is usually a busy place, for he is a respected person in the community and many visit him for reasons unconnected with healing, as well as those seeking therapeutic and prophylactic measures.

1. rakūba (Ar.) - walled sun shelter



3. TREATMENT CENTRE OF AN URBAN FEQI

For this reason, the feqi intersperses healing with discussions and advice-giving on all manner of topics.

Inside the rakūba, where the feqi sits (either alone or with a student or follower), there are rush mats and perhaps camel hair rugs and skins covering the floor. The feqi may sit on a wooden bed or on the floor but close by him, wherever he sits, are his loh, pen and inkpot - the tools of his trade. In the rakūba is usually to be found a collection of brightly coloured enamelled bowls of various sizes; these are waiting to be filled with miḥaya for those who are sick to use at home. For the majority of complaints the miḥaya is made from ayas¹ or sūras which are repeated hundreds or thousands of times. There may also be a number of small containers, bottles and jars if the feqi has added other therapeutic substances to his repertoire of healing practices. These substances are generally unlabelled and are known only by the feqi, many being detectable by smell only as they are contained in brown glass bottles. Usually the feqi also has a supply of aromatic substances which he may give to a client to use at home as bukhūr and also ambergris, a drop of which may be added to tea, giving a highly perfumed and exotic drink. These perfumes are said to come from Saudi Arabia, usually from Mecca, and are thus particularly prized. Good perfumes are also conducive to ridding a place of jinn and any other bad spirits who may be lurking, and are thus important in securing an atmosphere conducive to healing.

Feqis say that it is not they who heal but God and that they are only the vehicle of God's healing power. This healing power is an intrinsic part of the baraka (holiness, mystical power) with which feqis are traditionally credited.

1. aya (Ar.) - verse of sūra (chapter) of Qur'an.

7.2.1 Biographical sketches

Some biographical details of a number of feqis encountered in Darfur will indicate the variety of their individual lifestyles and the extent to which they are involved in healing.

An important rural feqi is Feqi Ahmed. He is the imam of the local mosque, a farmer, Qur'an school teacher and tailor. He has a much battered and dusty Singer treadle sewing machine in his rakūba and is quite often to be seen making a jellabiya or a dress during the less busy part of the farming year. During the planting and harvesting time, he is hardly to be found at home as he will either be in the fields or at the mosque. Feqi Ahmed is particularly known for his helpfulness and willingness to assist at any time and could be found digging or repairing a well in the morning and later on that day visiting a sick person, before going to the mosque to pray and then returning home to teach his pupils and play with his children, assisting his wife with supervising the children's meals.

Feqi Ahmed's wife is related to a practitioner of modern medicine and the feqi himself consults his affine when he feels that he cannot treat himself. He also prefers to take his children to a practitioner of modern medicine if possible, when they are sick. However, if no improvement occurs after modern medical treatment, he makes miḥaya. For the preparation of miḥaya, Feqi Ahmed uses holy words alone, he makes no additions of country or modern materia medica, as is the custom of some feqis.

The simple type of treatment given by Feqi Ahmed contrasts with that of an urban Fūr feqi, Feqi Abd el-Haqq. This feqi has a comparatively stylish treatment centre in his house, a brick built building of several

rooms surrounded by a high brick wall. Permission to enter is obtained from one of the feqi's sons and the individual and his or her relatives are ushered into the verandah waiting area at the side of the house. When he is ready, the feqi calls his next client, and client and kinfolk enter the apparently dark room, which is lit only by daylight from the open door. The feqi sits on the floor and the client and kinfolk join him there. He makes his diagnosis by looking into two cylindrical convex glasses which, he claims, were found in a cave in Jebel Marra. The sickness of the sufferer appears to him in the glasses and then, by the use of the 'great names' (names of God) he goes about the treatment. Feqi Abd el-Haqq was not prepared to show the actual way in which he calculates the healing formulae but he uses the numbers associated with each of the letters of the great names and code numbers for the relevant chapters and verses of the Qur'an. If the result of his mathematical calculations produces an odd number, healing will result and he makes the relevant miḥaya, bukharat or azīma for the treatment of the problem he saw in the glasses. According to Feqi Abd el-Haqq, anyone who cares to read the Sūra 'Ya sīn' 41 times on each of 41 days, can 'see' through his glasses. However, in order to be a successful healer, it is also necessary to read the Qur'an every seven days (unless sick) and to repeatedly ask God if one may be the means by which he heals the sick.

Although he does not accept payment for the treatments he gives, Feqi Abd el-Haqq accepts any cash or kind brought to him and is willing to treat any sickness except sexual diseases and goitre, which is found endemically in Jebel Marra.

Shaykh Muhammed, another urban practitioner of country medicine, is the leader of a ṣufi sect. He is an old man, about whom there are many miraculous accounts - of how he has been seen in two places far apart (in Darfur and Mekka) on the same day; of how he changed merīsa into milk when, before he was shaykh, he was thought to have some beer hidden in his house which, when he showed what was hidden, turned out to be milk; of how there is a glowing light over him as he sleeps; and many other stories.

Shaykh Muhammed spends most of his time sitting in his rakūba with his followers around him, talking to them and writing miḥaya or reciting verses from the Qur'an. He speaks individually to each person as they arrive and settle themselves on the floor, after first taking miḥaya. The followers may be coming for their daily visit and others may be visiting from afar, perhaps only passing through the town on their way to more distant destinations. Some of these visitors come to pay their respects and to gain his blessing, others come for advice or to be healed. Overseeing the proceedings and ensuring that the old man does not become too tired, is his eldest son (who will be the next shaykh) or his son-in-law - both school teachers.

The atmosphere of the shaykh's rakūba is busy and many people are usually present, sitting in groups and talking in lowered voices; it is a meeting place as well as a treatment centre. The shaykh advises, prescribes treatment, performs ḥazīma, talks to his followers and sometimes soothes a crying grandchild as people come and go. This is a totally different ambience for healing from the majority of others encountered in Darfur. However, although there is an air of bustling activity within

the rakūba, it is apparent that the shaykh and his client share a private consultation session.

Shaykh Muhammed never asks for payment, but most people give him at least a small bayad and another gift when they are healed. His followers do not bring a gift each time they visit him but do regularly make a donation of money, help him with house building, take him by car when he needs (he cannot walk very far) or, perhaps, bring him a sheep for the Ġīd celebration at the end of Ramadan.

As already indicated, the majority of religious practitioners of country medicine are men. However, one woman was encountered who was a respected 'feqiya' (her own description of herself). This title indicates her knowledge of the Qur'an and she often teaches small children, having studied at the Qur'an school (som), run by her father.

Feqiya Batūl is about 25 years of age, married but childless after six years of marriage. This is the main factor, she says, which has led to her continued study of the Qur'an. When she has finished her work on the farm, Batūl looks after the children of her co-wife (her cousin and good friend) and those of other kinfolk who live close by. At this time, she teaches the children their first verses of the Book. If a child is sick, Batūl performs Ġazīma if the mother requests her to do so, although she maintains that she would rather take the child to hospital. She, herself attends the hospital when she is unwell, but also makes miḥaya if she has a headache or some other minor problem. According to her, Ġazīma is the most correct way of utilizing the holy word for healing purposes and evidence for this is to be found in the Ḥadith.

Feqi Zakhariya attended Qur'an schools for 36 years before he decided to settle down and become a practitioner of religious country medicine. At this time there was a lack of water in the area where he wished to set up home and establish his treatment centre, so he decided to make his home near to the wadi. He prayed that there should be water and apparently a small pond appeared in the dry river bed near his home. He started to treat people at this place. His clients came from other parts of Sudan and also from Chad. He remained by the wadi for five years and when he moved to another place nearer the small market town, the pond dried up.

During his time by the wadi and in the three or four years since his move, he recalled treating more than 60 women for infertility; all but one of his cases was successful, he maintains. The unsuccessful case was one in which the woman's husband insisted that she attend the hospital before he had completed his treatment. He heard later that she had had an operation and twins were born, one of which died. The other baby survived and was three years old at the time of interview (1979).

While he was a student at the Qur'an school, Feqi Zakhariya had a dream in which someone came to tell him that he was to treat the sick and proceeded to instruct him on how to do so. He now works continuously, seeing a number of clients each day and between treatments he makes miḥaya and reads the Qur'an. His wife and children go to the farm daily. He always makes a charge for each treatment, informing his clients of the price beforehand. If people cannot pay his price, he usually sends them to another feqi. He is willing to be paid in either cash or kind.

Feqi Zakhariya has books on Arabic medicine and also some which are a mixture of Arabic medicine and magic; all are in a sad state of repair. He spoke about malāriya and bilharziya as being two fairly common and problematic sicknesses and about the problems of poor housing and lack of sanitary arrangements, an inadequate diet, alcohol, stagnant water and flies. He is willing to treat all forms of sickness and makes his diagnosis and initial part of treatment with the help of the sick individual, who uses a small stick which is inserted between the pages of the Qur'an, at which it is opened. At the top of the right-hand page, at the place opened by the client, is the verse which will lead the feqi to the specific verse for the problem in question, via his own code for the diagnostic process. This is the process known as 'opening the Book'. Like Feqi Abd el-Haqq, Feqi Zakhariya would not explain his codified diagnostic process any further.

7.2.2 Techniques of therapy and prophylaxis of the feqi

Feqis, in general, utilize the holy word in their healing and prophylactic procedures. There are five important techniques - Cazīma, miḥaya, bukharat, hejabs and recitation.¹

Cazima is the murmured recitation of certain verses from the Qur'an where the feqi pauses after every phrase or sentence to blow towards the sufferer, as if blowing the words over him or her. The performance of Cazima may take a few minutes or much longer (half an hour or more),

1. Apparently, such techniques are also employed by feqis who engage in black magic and sorcery, substituting non-holy, magical words.

depending upon the decision of the feqi concerning the number of repetitions and the length of the section of the Qur'an which he considers to be most suitable.

Mihaya is made by writing verses from the Qur'an on a wooden board (loh) with locally made ink and washing this off with water into a receptacle. The greyish-blue liquid erasure is then usually drunk but may also be used to bathe the affected part or the whole body. Mihaya may be taken daily or whenever desired; it may be obtained in bulk from the feqi or the individual may visit the feqi daily or just when he or she feels the need. Those who are followers of a feqi or a shaykh usually visit him daily and when they have greeted him, they take mihaya from the central vessel which is kept topped-up with an all-purpose preparation. Sometimes people send a vessel to the feqi for him to fill with mihaya at a later time because some varieties of mihaya have to be written hundreds or thousands of times. This is usually completed by the feqi's assistants or senior students (muhajarīn).

When an individual is sick and visits the feqi for mihaya, or the feqi decides that mihaya is the correct therapy for a particular ailment, the sufferer is often asked to 'open the Book' as a prelude to treatment. To do this, the individual takes a piece of dried grass as a marker and pushes it between the pages of a closed Qur'an, after repeating seven times 'Bismillah el-Rahman el-Rahim' ('in the name of God, Most Gracious, Most Merciful'). The Book is then opened at the page indicated and the verses, beginning at the top of the right-hand page are then written on a loh and washed off with water into a container. The resulting mihaya is



4. PREPARATION OF MIHAYA - WRITING ON LOH

then drunk by the individual. The number of times the verse needs to be written is dependent upon the first letter of the page, each letter having its own number. See photograph 4 - preparation of miḥaya.

A feqi may, however, write a selection of verses that he chooses. They will be significant perhaps for the number of times one letter is repeated as for example in the Sūra XI, Hūd, aya 50 which is related to peace and blessings, the letter mīm (m) is repeated 21 times. Another method employed in the making of miḥaya is to take the name of the sufferer and place the letters in a combination with the letters of Allah and of Muhammed and then to write a verse which starts with each letter.

Following whichever method for choice of verse, the portion deemed suitable for the particular ailment of the individual is written on the loh, completely washed off into the receptacle and then this process is repeated however many times is necessary. Sometimes the verses are written out and sometimes a coded form is written, with letters, numbers and other signs in squares, said by the feqis to represent verses from the Qur'an. This encoded version is usually accompanied by some written words. The majority of feqis have in their possession several copies of ancient books which contain many magical formulae (some are symbolic devices, others are laid out in squares) which are said to have been derived by Muslim mystics and religious scholars in centuries past. (The origin of magical squares and manipulation of numbers is thought to have come from India or China before the time of Pythagoras.)

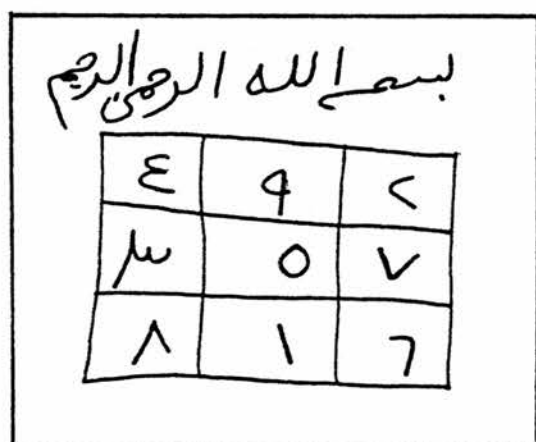
Urban feqis often make additions to their miḥaya. These additions may be in the form of perfumes such as musk and rosewater or crystals of

camphor or saffron. Sometimes, powdered aspirin or antidiarrhoeal tablets are added too.

Bukharat are small pieces of paper on which the feqi writes verses from the Qur'ān, or perhaps some of the names of God, or draws squares consisting of a significant number of cells, each of which contains letters, numbers or other signs. Usually the papers are written in strips of seven, for two or three weeks and the individual is instructed to burn one paper daily by placing it in an incense burner. He or she should then sit near the burner in order to be fumigated by the smoke from the smouldering incense and papers. (It is a common practice in Sudan to burn incense to fumigate the houses and to give a pleasant smell; it is also a belief that good smells will drive away evil spirits.)

Bukharat are used commonly for sterility by women and sometimes for those who are believed to be possessed by jinns. The example shown below was used by a number of feqis encountered in Darfur and is also illustrated in one of the old books on medicine and magic.¹

Figure 2 EXAMPLE OF MAGICAL SQUARES OFTEN USED IN BUKHARAT.



1. Manbaʿuṣṣūl el-hikma (The source of the origin of wisdom) first published in 622 AH. It is also illustrated in Ahrens, W. 1917:186 as he translated it from Jābir b. Ḥaiyān (Dschābir ben Haijān) who died in 776 AH.

Figure 3 TRANSLATION OF SQUARES

In the name of God, the merciful, the compassionate

4	9	2
3	5	7
8	1	6

In such a square, all the rows of numbers, across, down and diagonally add up to 15, the feature which gives the square its magical properties, (see also Goody, 1968:18).

A hejab is an amulet, though strictly speaking, the name refers to the leather covering in which the amulet is sealed. The amulet itself consists of a paper, folded a number of times and bound up with cotton. On the paper are verses from the Qur'an and possibly there is also one of the squares mentioned above or a more complex device believed to be specifically beneficent for the problem.

Hejabs in particular, are used as prophylactic measures and are worn by virtually everyone in Darfur. Once prescribed and worn, they are never abandoned, but are kept with others the owner may possess. Women wear them on a long leather string across their bodies, often with small mirrors set into the cover; men wear them around the upper arm attached to a small leather strap. Soldiers nearly always have a hejab to protect them from bullets.¹ Photograph 5 shows a woman wearing a hejab.

1. Such hejabs are said to be tested for effectiveness by their owners by shooting at a sheep which has the hejab around its neck. Despite many claims by soldiers that their hejabs had saved their lives, no-one was willing to demonstrate the effectiveness of his hejab on a sheep, during fieldwork.



5. WOMAN WEARING HEJAB
(note mirrors against the evil eye)

Recitation of verses from the Qur'an a popular form of therapy in Darfur, is carried out by feqis for a sick individual. The verses may either be chosen by the feqi himself or by the sufferer by the process of 'opening the book' already described. Particularly in the villages of Jebel Marra, group recitations are carried out either in the mosque or in the home of the sick person or the home of a feqi. Such a group treatment is known in Darfur as a towisa.¹ Mihaya is also prepared by a towisa sometimes. Several people are collected together either in the mosque or the home of a feqi, usually, and they then write the appropriate section for the mihaya in order that the prescribed number of repetitions, (several thousands), may be quickly accomplished.

A feqi may use his rosary in the performance of Cazīma and in the recitation of portions of the Qur'an. The rosary may act as a reminder or counter, with a prayer or verse repeated for each beat, or as a counting device to record the number of the recitations. It may also be used in the diagnosis of a client's sickness and in the selection of the verse suitable for treatment. The formula for revealing the therapeutic verse in the Qur'an involves calculations using the numbers relating to the letters of the client's name and perhaps also his or her mother and the name of the day of the week, or whatever the feqi considers appropriate.

The techniques described above may be used to treat almost any sickness. No method is regarded as being the only way to treat a certain condition. From the religious point of view, Muslims regard Cazīma as the 'proper' method, although the majority of feqis seem to use all methods.

1. Towisa is also the term used for the group which gathers to help in farming - see p.107.

Informants who consult a feqi are prepared to accept whatever kind of therapy he offers. If the first treatment or series of treatments do not bring relief, the feqi may continue with the same type of treatment but using other verses or arrangements of squares, or he may decide to try another method.

During fieldwork it was found that Cazima was used to treat arīt (probably epilepsy), malāriya, sterility, impotence, labour difficulties, kewa (leprosy), emotional and mental disturbances and evil eye sickness; miḥaya was used in the treatment of abdominal disturbances, labour difficulties, arīt, headache, the evil eye, sorcery, wounds, malāriya, emotional and mental disturbance; bukharat were used mainly for women's problems, sterility, emotional and mental problems; hejabs, as small items easy to carry on the person were used prophylactically against the evil eye, to ensure fertility and in general to protect against any possibly harmful occurrence; recitations were carried out mainly for malāriya, labour problems, emotional and mental disturbances and headaches of long duration, by groups of villagers in Jebel Marra.¹

7.3 THE SPIRIT HEALER AND DIVINATION EXPERT

There are a number of different spirit healers in Darfur, the majority of whom are found in urban areas. In general, the spirit healers are female; although two accounts were given of male spirit mediums and one was encountered. Spirit mediums are included in this section for, although

1. For individual treatments of specific conditions, see Appendix 3.

they do not actually practise any healing techniques, they are sometimes instrumental in deciding whom a sufferer should consult for healing. Such spirit mediums are known as jiddonga (F) in Jebel Marra but more commonly as jinny (F. and Ar.) in and around Zalingie. Another medium, who also practised healing, called herself a kujuriya (Ar. coll.) after the Nuba healer, the kujūr. A zar shaykha¹ is the leader or manager of a cult whose adepts believe they are possessed by spirits, which need periodic placation by the individual dancing to drummed music in costume, drinking alcohol and smoking and being given presents of perfumes and clothes. Divining and fortune-telling are often to be found as skills of the same person. Such individuals are constantly visited by those who feel they are sick and need to know the nature of their problem and whom to consult and, possibly, the outcome. A ramāla (Ar.) is one (usually a man) who divines by sand-gazing and a wadaiya (Ar.) is a woman who uses the cowrie shells (wadi^ca, Ar.) in her divinatory practice.

The jiddonga and the jinny seem to have similar characteristics, although as neither were personally encountered in Darfur it is difficult to be sure. Two informants seemed fairly certain that these were two names for the same practitioner. In any case, it seems that the skill of the practitioner is a dying one, for the majority of younger people had never heard of one - in Zalingie and Jebel Marra.² One account is of a practitioner who attends on the days of the market (Tuesdays and Fridays) in a village in the foothills of Jebel Marra and there is report

-
1. zar shaykha (Ar.) - There would appear to be no Fūr equivalent and the zar phenomenon is of recent import to Zalingie; it is a popular event in urban areas particularly in Omdurman, among relatively deprived groups.
 2. It is possible that the practitioner is better known in the north of Darfur around Kutum and Fatta Bornu.

of another in a village on the way to el-Geneina from Zalingie. A travelling jinny attempted to help the parents of a girl who had fits and was slightly mentally handicapped, by trying to divine what was causing her problem but this was apparently unsuccessful. A few informants in Garsila also knew of the term jiddonga but did not know of a practitioner.

According to informants, jiddonga is the Fūr interpretation of the Arabic jadd (grandfathers or ancestors) and it seems to refer to both the spirits and the individual who mediates between them. Also, informants were not all in agreement as to whether there is always another individual involved in this practice to translate what the spirits say to the jiddonga.

The jiddonga is consulted in a cottage which has a screen across the section opposite the door. Behind the screen is the jiddonga. He or she is usually an older person, at least of 40-45 years of age. The jiddonga may speak in his or her 'spirit language' all the time, so requiring an assistant interpreter who sits with the client, or who may speak to the client and then speak to the spirits, following with his/her own interpretation.

As far as it was possible to ascertain, jiddongas become aware that they can communicate with the spirit world; there is not necessarily any training for this practice and it is not always passed from parent to child. One point seemed to be agreed upon by all informants - those who take up this practice are doing so in order to make monetary gain.

The majority of spirit healers, it seems, are women. Those who engage in spirit possession (in Darfur) are virtually all women. All those encountered gave a history of some sort of emotional problem, as well

as physical symptoms, before finding relief in spirit possession. Although, one practitioner maintains that she has some Fūr women in her zar group, none were encountered who claimed or admitted membership. The great majority of women who are concerned with spirit possession and spirit healing in Darfur, are Arabs.

7.3.1 Biographical sketches

Aīsha is an example of a spirit healer, calling herself a kujuriya. She is an Arab from the southern part of Jebel Marra, and had been living in Nyala for some 6 years when interviewed. She is illiterate and did not attend Qur'an school. By her behaviour and conversation, she gave the impression of being an unusual personality, very talkative and high-spirited. She was first visited by spirits during her teens, some 30 years prior to the interview, and now calls them while counting the beads of her rosary. When they answer her, she asks the spirits to show her the sickness of her client and how it may be cured. She then proceeds to prepare the medicine - 'water and Cazīma of the spirits', with perhaps some other additions. Aīsha says that her treatments are expensive because she has to fight against malign supernatural forces to cure the sufferer of the effect of the evil eye and sorcery. She charges a fixed sum before embarking upon the work and is paid either in money or sugar.

The female spirit healers encountered had commonly undergone some form of disturbance which was diagnosed as dastūr (Ar.) or zar (Ar.) (spirit possession),¹ enchantment by the evil eye or sorcery. The cures for their

1. For a description and analysis of zar spirit possession in Northern Sudan, see Constantinides 1972 and 1977.

problems and allowed them to become able to help others. Mariam was troubled with dastūr some 12 years prior to interview. She consulted doctors in several towns but failed to improve. Following this, she sought relief from various feqis and eventually from a shaykha in Nyala. While undergoing therapy with the shaykha, she promised an ox karāma¹ if she were to be cured. Her own treatment, by zar ritual, lasted for six days. Afterwards she began to feel better, having come to terms with the spirit possessing her, and she began to organize similar ceremonies herself for the women in the area. Mariam claims to have treated some 40 women and 2 men for dastūr. Many have come from far afield for treatment. However, this kind of spirit possession is basically a woman's problem in Darfur. (Apparently there is a growing number of men in Omdurman who take part in zar ceremonials, as participants, not just as drummers and singers. There are also some male leaders of zar spirit possession cults in Omdurman.)

Payment for this type of treatment is high.² The shaykha herself must be paid and then there is the sheep which is killed during the ceremonial and the drink, perfumes and cigarettes for the party. The sufferer herself must also be given the items of clothes and jewels which her spirit demands, before it will leave her. All this must be paid for by her husband.

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1. karāma - a token of esteem, respect/to honour someone, in this case as a thanksgiving to God.
 2. Perhaps as much as £20 sterling, the sheep may cost £10. Such outgoings must be considered against a cash income of £50-£80 per annum, and less in many cases, (although the World Bank Atlas gives a GNP per capita of over £300 for 1980).

Zaynab, an urban spirit healer also experienced a long illness with headaches and feelings of anxiety, which according to her, a number of doctors and feqis could not cure. It occurred about 45 days after the birth of her third child, when a woman put oil on her head at a party. Perfumed oil is often used at women's gatherings, especially when the guests are leaving; the hostess, usually, gives her guests a dab of sandaliya (Ar.) - sandal oil - or the exotic khumra (Ar.) perfume. Zaynab, however, is certain that this woman touched her with oil which had been sorcerized.

During the fast of Ramadan, when apparently she became blind, she had a vision of the Prophet Isa (Jesus) and two angels who took something bad-smelling from her head. They instructed her to make a mixture to put in her eyes and told her she would be healed. At this time she began to have contact with her spirit, Menazil, and was in fact cured. She says that Menazil is a kind of zar, with a 'bright and lovely face' but she is not sure if it is male or female. It always appears in shining white and speaks to her only. This spirit helps Zaynab to diagnose and treat individuals who have problems with spirits, the evil eye and who have been the subjects of sorcery. It also helps her to tell fortunes and to answer questions regarding marriage and job prospects.

For a consultation, Zaynab accepts a bayaḍ, money usually. She does not demand further payment but it is customary for clients to bring her a gift later when they have found relief or perhaps when her fortune-telling has come true.

Fortune-telling, using cowrie shells, is something most women in Darfur indulge in occasionally. Very few women have expanded their flair for divining and fortune-telling into a full-time occupation, but one such woman is Khadija, an elderly Fūr widow who lives with her daughter and her family in the centre of an urban neighbourhood. She is active for her age (over 80 years), intuitive and full of fun. She sits on a locally made, low wooden bed in her rakūba most of the day and there is a steady stream of callers to the house. She sees her clients individually and privately, due to the nature of her vocation which is divination and fortune-telling. The majority of her clients seek knowledge about marriage, health and business prospects and the old lady uses small cowrie shells (wadi^Ca) to focus her predictions.

Casting the wadi^Ca is something many women do, to make decisions, to pass the time, to entertain their friends. They show varying degrees of faith in what they read from the shells or are told by the reader. Children are very familiar with the shells and small girls often try to play with them and may be encouraged by their grandmothers. This was the case with Khadija. When she was small, her mother and grandmother and other female relatives encouraged her to read the shells, realizing that she had a gift for interpretation and was by nature intuitive. For simple health, marriage and business forecasting Khadija accepts a small bayaḍ but for a more detailed therapeutic reading, perhaps with advice or even therapy, she charges in the region of £S5, on top of the bayaḍ. Occasionally, she makes medicinal remedies for her clients, for 'difficult' cases such as impotence, from recipes taught by her grandmother.

7.3.2 Techniques of spirit healing and divination

Spirit healers and mediums who give advice concerning sickness and who might cure it, often use the technique of speaking, in a language unknown to others, with unseen spirits whom they manipulate to give diagnoses, advice on healing and glimpses into the future. Occasionally, use is made of an assistant who interprets the spirit language to the client but, in general, those encountered in Darfur worked without any assistance from others.

When consulting such a healer or diviner, the individual goes to the home of the practitioner, if possible at the usual, known consulting times - on Friday mornings and particularly in the late afternoon or early evening, but this varies from one practitioner to another. The practitioner will probably be in his or her small cottage which functions as consulting room or in a rakūba. Inside the cottage there is usually a screened-off section where the healer is waiting. Usually the client introduces himself or herself and states the problem, at the same time offering the bayaḍ. Sometimes the practitioner needs something owned by the client, such as a handkerchief. (Zaynab slides a metal board under the screen for the client to place his or her palm on for a few seconds, before returning it with the bayaḍ). The client then is instructed to think about his or her problem or the question requiring answer. If it is a medical problem, some healers seek further indication of its nature. After this, one hears the voice of the practitioner speaking with his or her spirit in an unknown language and she then translates the reply. The voice of the spirit may or may not be heard. For some problems, female spirit healers such as

Zaynab, give the client some perfume or incense to burn after performing certain simple rituals (such as ablutions or having a pair of pigeons moved over the head before killing and cooking them for eating).

Ventriloquism seems not to be used by female spirit healers and usually one does not hear their spirit voices. It would appear from informants, however, that men engage in some techniques of illusion. The one feqi encountered who regularly spoke to his jinn in the company of others, was quite successfully employing ventriloquism. However, when behind the screen of his consulting room, the sound was as if he spoke into a glass to gain a different sound for his jinn.¹

As far as can be ascertained, the technique used by the jiddonga is similar to those described above, except where an assistant interprets the words of the spirits. These spirits may or may not be personal ones.

When a zar shaykha is consulted by a sufferer who may be troubled by dastūr, she usually gives some perfume (such as khumra) in return for the bayaḍ and 'sleeps on the matter'. During her dreams she hopes to see one of her own spirits who will inform her of the client's complaint. If the spirit says that it is, indeed, dastūr then the shaykha will bring together her group of initiates and they will dance and sing the tunes of their spirits. All the tunes of the various types of zar spirits are played, in order to ascertain which is the one troubling the new client. When she eventually falls down in a trance, it is believed that her spirit is the one for whom the tune is being played. The shaykha then speaks

1. When the feqi came out from his screen he accidentally pulled the curtain back too far and revealed the glass on a table.

to the spirit and discovers what it wants in the way of gifts to allow the woman to be able to recover. These requests for gifts are quickly transmitted to the woman's husband. Requests are usually for tōbs, perfumes and gold jewellery. Then the shaykha 'awakens' her client and she rests for some time. When her spirit has been identified, the woman will make herself a costume to correspond and she will use this for subsequent attendances. She will dance with other women, but will only become entranced by the tune of her own spirit.

Some shaykhas become entranced themselves with one of their spirits (they usually have learned to control several) and then divine the troubles of others and heal them. For this process, they dress in the appropriate costume and burn incense in seven special pots (mubkhurs). The sufferer then sits on a mat on the floor, facing east, while the shaykha addresses her spirit. She may use other accessory rituals in her divination, such as coloured beads or bracelets or the cowrie shells or she may use a metal object to touch the sufferer to tell where the problem is.

Diviners who use cowrie shells take the seven shells in one hand, shake them and then throw them (similarly to dice). They then read, from the positions and juxtapositions of the shells, what they fore-tell. Shells may indicate communication or relationships with men (the dome of the shell being uppermost) or with women (the opening of the shell is visible), or travel.

Some diviners, mainly men, use the sand as their divining medium. They make marks in the sand with a finger and follow a progression of calculations using these marks. The answers to various questions put by



6. SAND DIVINATION

the diviner to his simple 'calculator', are then drawn together to give a reading to the client. See photograph 6.

Another variant in divining techniques was demonstrated. He takes two supple sticks, holding them lightly against the anterior aspects of both shoulders. The client takes the other ends and holds them in the same way. The feqi, with eyes closed, asks the client to think of his or her questions - with regard to marriage prospects, health or business. For this divination, no questions are asked by the feqi. If the answer to the question is 'yes', the sticks bend together in the middle, if 'no', they bend apart.

7.4 PROPHYLACTICS AND THERAPEUTICS OF THE FEQI, SPIRIT HEALER AND DIVINATION EXPERT

The feqi is believed to have a link with God and it is not difficult to see the reason for this. He is always associated with the holy word and not only speaks it by heart but can also write it down and can thus manipulate it for therapeutic and prophylactic ends. Feqis undertake religious exercises such as fasting and remaining awake, praying, all night or for several nights. The object of such exercises of deprivation is a mystical one: the attaining of gnosis. The knowledge of spiritual mysteries, in which it is assumed that the individual becomes one with God, even if only momentarily, results in the ascription of baraka (blessedness or holiness) to that individual. There may also be amazing stories associated with a feqi, which are regarded as proofs of his 'special' character, such as those, referred to earlier (page 287), about

Shaykh Muhammed. Another feqi was reputed to have been found unharmed when, as a boy, he was discovered, still sitting calmly and reciting a portion of the Qur'an, after the cottage in which he sat was burnt down.

In a pre-literate society - and much of Fūr society is still not literate, formal education not having begun until the 1940's and Qur'an-literacy commonly only resulting in the ability to copy and to repeat by rote - words have a mystical power, particularly written words. Texts, words and numbers committed to paper or to the loh can visibly be manipulated; they can be hidden and secreted away, burnt to form smoke and dissolved in water to be ingested. Illiterate people may also feel that the word written down gains potency above that of the whispered or spoken and blown word, although, it is said by the majority of feqis that Cazīma is the purest and most correct way of utilizing the healing power of the holy word. However, miḥaya, with its more tangible properties, would appear to be used as much if not more in prophylaxis and therapy. Miḥaya has the advantage over Cazīma that it is taken internally, rather than being blown over the sick person or the individual requiring its auspicious properties. This is also the case with the burning of bukharat, for the smoke is believed to permeate the whole body, inside and out and is breathed in by the sick person who sits in the smoke, over the incense burner. Bukharat may contain written words and numbers and other figures apart from the words of the Qur'an. The manipulation of numbers, with or without the addition of other symbols, can potentiate their magicality. Squares are often used in the arrangement of numbers, as shown in Figure 2. Magical properties are assigned to the numbers according to their mathematical characteristics.

The words, numbers and symbols of hejabs form the most lasting type of therapy and prophylaxis, in which the written word is hidden away close to the body. A non-literate or semi-literate individual can, thus, actually handle and keep his own special piece of magic, which he believes actively and positively works for him, predisposing him to the beneficial aspect of life. The leather case in which the amulet is kept, may itself be protected from the evil eye by small mirrors. Mirrors, it is believed, reflect the evil eye back to the individual using it.

Group or individual recitations of portions of the Qur'an, repeating the portion many times, has the power to heal (providing God wishes it) due to the joint effort of willing the healing to take place, or to the single will reinforced by repetition. The words themselves contain healing power, released in this instance by repetition and believed by the Fūr of Jebel Marra to be a particularly powerful method of helping the sick.

Ritual, in general, adds sacred overtones to a therapeutic procedure. Ritual ablutions, recommended by fegis and spirit healers as a prelude to further therapeutic measures, symbolically cleanse the individual from past sins and from association with any detrimental forces. Any incense or other fragrant perfume will then make way for beneficial forces, for good spirits and the restoration of well-being.

Perfumes are particularly important in spirit healing, creating the ambience which evil spirits are believed to shun and which encourages good spirits or those which may be trained and tamed and beneficially employed. In the zar ceremonial, incense and the heavy, musky perfume, khumra, are used liberally, creating a heady and smoky atmosphere in which it is easy to believe that spirits flit and hover.

Spirit possession has been interpreted by Lewis (1966; 1971) and Constantinides (1972) as being due to the relative deprivation of peripheral groups in Muslim Arab society. Such an interpretation would be germane to the situation in Darfur, where spirit possession cult members are mainly women and, in the majority, Arab. The lack of Fūr women as spirit healers or as cult adepts is, perhaps, not surprising when one considers their independent attitude to life and generally greater social freedom.

Whereas the feqi is presumed to have knowledge of spiritual mysteries (ma^Crifa, Ar.), other practitioners who have dealings with the spirit world or with the mystical aspect of life in their healing practices, have almost always had some kind of personal problem which has been associated with psychic experience. Spiritual experience is regarded as an essential requirement for a practitioner of medicine in the field of mystical healing.

The number 'seven' features on numerous occasions in therapeutic techniques, particularly those of the feqi; it is also used by divination experts and home therapists. Therapy may involve recitations or performance of azīma, seven times or 777 times. Seven bukharat, or multiples of seven, are given for burning by sufferers on consecutive nights. Some feqis use the number seven in the ritual of 'opening the book' - the client repeats 'Bismillah el-Rahman el-Rahim' (In the name of God, Most gracious, Most Merciful) seven times before inserting the small stick between the pages, and then the feqi chooses the page seven from that originally selected. One feqi used a formula to find the 'secret of the name' of his client, the result of which calculations should be seven if the client is to recover from a sickness.

Seven cowrie shells are used by the divination expert in the variety of techniques which enable the foretelling of the future in healing, business dealings and affairs of the heart.

Seven is the most powerful and sacred number and has been so since the times of the Chaldeans. The number seven is related to the seven planets known at that time and was auspicious because the lunar month could be divided into four quarters, each of seven days - the planetary week.¹

7.5 THE HERBALIST OR OWNER OF ROOTS

Although perhaps not a herbalist in the usual sense of the word, this is not really an inaccurate description of the 'owner of roots' (korongadonga).² The herbalist is usually a person of some stature in the community, whose wisdom and skill in the use of roots is widely acknowledged. The owner of roots is not strictly confined to the use of roots but may well include other parts of the tree or shrub in his or her repertoire of remedies. The prestige of the healer is, however, closely associated with the root treatments, perhaps due to the skill necessary in identification of trees which yield efficacious roots, but also to the secrecy surrounding the

1. See Goody, 1968 and the Encyclopaedia of Religion and Ethics, Vol. IX:416, for Cruickshank on 'Sacred numbers'.

2. The korongadonga (F.) is one who owns roots, but only when they have been cut from the tree. Anyone may take roots from a particular tree, the tree itself is not regarded as the property of any one individual. Hence the secrecy surrounding the whereabouts of particularly prized trees.

location of these trees and their uses. The herbalists are rarely willing to teach their skills to others as this would cause competition and endanger their unique position. They tend therefore, to impart their knowledge only when advanced in years and when a relative is keen to learn or if a stranger comes from afar and shows a specific desire to undertake an apprenticeship. Owners of roots regard it as an important matter that they leave their knowledge in good hands.

The majority of herbalists encountered in Darfur are at least middle-aged, and most of the experts in this speciality are men. It is usually a part-time specialization, though by no means always. There are, however, a number of people in most communities who have some knowledge of the roots which can be used in a few complaints, presumably as a first-aid measure. The experts claim to be able to treat a wide variety of problems, including stomach troubles, diarrhoeas, worms, skin conditions, eye problems, sterility, snake bites, fevers and venereal diseases.

Some herbalists do perform a brief examination of the part of which the sufferer is complaining and may palpate the area, paying particular attention to skin conditions. This is in contrast to fegis who see the person sitting in front of them and are either told of the complaint, or simply that the individual feels 'unwell'. Sometimes a fegi will also treat an individual in absentia, having been informed of the complaint by a kinsman or kinswoman.

In general, herbalists accept money or a gift of sugar or some other food item in payment. The payment is usually made after the consultation and treatment, but some healers do insist on being paid first, fearing

that the individual, once cured may not wish to pay later. Often they have a stated payment for each of their treatments and some cost several pounds, especially if the root is rare or only to be found at some distance.

7.5.1 Biographical sketches

An acknowledged female expert in this speciality was encountered in Jebel Marra. Um el-Nūr is a herbalist with expertise in the diseases of children. She is in her mid-fifties, a farmer, housewife and mother. She attended Qur'an school when she was a young girl and learned about the medicinal characteristics of shrubs and trees from her father and grandfather, both important shaykhs in the area. Perhaps partly because of her family background, but mainly due to her own personality, Um el-Nūr is a woman of repute, whose opinion is often sought by both men and women. She has a large family and her two eldest sons have completed their university education.

Individuals seeking help from Um el-Nūr come to the homestead and are invited into her cottage or to sit just outside, depending upon time of day and season. The usual time is early morning, when she is milking her cows or having her first glass of hot, sweet tea. They drink tea with her and she assesses the problem so that she can collect the necessary plants during the day, while going to her farm. Sometimes, however, the searching for plant materials takes most of the day. When she returns home, probably after sunset, she prepares the medicines in her home or takes the materials to the home of the sick individual for preparation

there. No payment is asked for the plant materials although most people repay with sugar during the next few days. The majority of Um el-Nūr's clients are her kinfolk or affines as she is related to most people in the area.

In the past Um el-Nūr has delivered babies but nowadays the modern medical midwife, a young woman from the next village who is a kinswoman of Um el-Nūr, looks after most confinements. However, if the newborn baby is not progressing as might be expected, then it is likely that she will be called before any other practitioner is consulted.

Ibrahim is a man of about 45 years, a farmer and middleman in the markets of Jebel Marra. Much of his time is spent travelling between markets while his wife looks after the farm. Because of the lack of medicines in remote settlements, he decided that he would learn some of the treatments known to certain old women in a large market village in the south of the mountain range. He visited these old women and persuaded them to teach him their skills. He is now considered to be quite an expert in the treatment of skin conditions, stomach troubles, kidney pain, venereal diseases and colds.

Whereas Ibrahim's practice in Jebel Marra seems to be flourishing, that of Musa, in a village near Zalingie, has almost disappeared. Musa is an old man in his seventies, whose speciality is the treatment of venereal diseases. During recent years he has seen hardly any individuals with this complaint, due to the success of the treatment with penicillin injection, which can be obtained from a hospital or from a market trader who deals on the black market. The old man learned of the treatment when

he suffered the disease himself and was treated by a friend in the north of Darfur, perhaps some 30 years prior to the interview. At this time he was used to treating as many as five or six people a day. Musa studied for eight years in Qur'an schools and as a young man, travelled on foot to the Gezira to work. He spent a year there picking cotton before returning to his farm in Darfur.

Ismaïl is perhaps more of a pharmacist than a herbalist. He sits with his wares in the market-place under a small shade which he has erected to give some protection from the sun. People tell him about their complaints and he suggests the remedy. He has crushed, powdered and whole roots, bark, leaves, powdered rhinoceros horn, certain inorganic substances and a variety of other dried items, many tied up in small bundles. With the sale of each item, Ismaïl gives instructions for use.

Ismaïl has travelled widely and made contacts in many places. He knows where all his remedies may be obtained and when he hears of an individual travelling to a distant place, he may ask that person to bring back a supply of particular medicines. Sometimes other herbalists bring materials when they come into the market from distant villages. Thus, it seems that this man has a network of friends and acquaintances who keep him supplied regularly with materia medica. He is to be found almost every day in the market and has a slow stream of clients throughout the day, consulting him and buying his wares.

Usman is a farmer of some 65 years. He specializes in root treatments and is well-known in the area for his snake-bite and scorpion-sting antidotes. He has been practising as an owner of roots for about 50 years

and has collected his information from many sources (according to his son), although he insists that his knowledge comes only from Allah. Usman is certain that he can treat most sicknesses and has the necessary roots or can obtain them without too much difficulty. He was once gored by a bull and was taken to hospital for treatment. He was pleased with the way he was treated and thinks that such injuries are best treated by modern medical practitioners. Systemic problems, however, he believes to be best treated by country medicine. This is a common sentiment among owners of roots.

People coming to seek Usman's help come to his spacious homestead, tether their horses or camels if they have come by this means from afar and sit under his shade-roof to await him if he is not at home. They are made tea by one of Usman's daughters or grand-daughters (his wife is very disabled and has difficulty walking) and when he arrives, they talk to him about their complaints. If there at the time of prayer, all male visitors join to pray together after performing their ablutions. Thus, the process of seeking therapy becomes a sociable affair. Women clients usually wait with the women of Usman's family until the men leave before consulting him. It is quite common for the male relatives of women living further afield to seek treatment on their behalf, explaining the symptoms and receiving the relevant medicaments to take back to their sick womenfolk.

7.5.2 Root medicines - forte of the owner of roots

The herbalist or owner of roots collects roots, and sometimes other parts of plants and trees - such as seeds, bark and leaves - and prepares

medicines from them by decoction or infusion. The plant materials may be cut into small pieces or powdered or used whole. The medicine may then be applied to the area or taken orally. Plant materials may also be used as a poultice.

Owners of roots do not claim the trees from which they take their roots, for they say that anyone may come to take the roots if he or she knows a use for them. The locations of trees whose roots are valuable in healing are usually kept secret among the owners of roots and there is some co-operation among them with regard to the trees. For example, if one of them needs a root, he can ask another who is travelling to bring back the root for him. Ismaīl, the korongadonga who sells roots (among other things) in the market, is often brought roots from afar by others who are more mobile. Those who treat with roots usually keep a small stock of the more commonly used varieties, powdered or whole, but when a less common root is required, they must go in search of it.

A great variety of root treatments were encountered during the course of fieldwork, from herbalists and from home therapists. Roots are used in the treatment of abdominal disturbances, such as dysentāriya or deyongwey and osūra, (whose symptoms are similar to diarrhoea and constipation), gynaecological troubles, the induction of abortion, coughs and colds, dog and snake bites, impotence, jaundice, venereal diseases, mental problems and symptoms of evil eye affliction.

Many of the plant materials used by herbalists are also used by home therapists. Some of them are known to everyone, even to those not interested in medicine. However, these other materials do not have the mystique of the roots, partly because they are always visible, unlike the

hidden roots, and also because it is realized that much skill and learning goes into the recognition of roots and their uses. Following the next section, which concerns the home therapist, a number of plant treatments are described. These treatments, although often discussed by owners of roots are probably fairly well known, particularly to home therapists. Owners of roots are very secretive about their materia medica and would not have disclosed their specialities, knowing that the present study involved the interviewing of numerous other practitioners. The small village communities are close-knit and little remains a secret unless the information is contained - in such a case as between teacher and apprentice. On numerous occasions, owners of roots showed great enthusiasm to discuss their treatments, but they either would not name the roots they demonstrated or would not demonstrate the roots they named. None were willing to show where they found their roots. The more common roots, barks, seeds and leaves were named, but quite often only in the Fūr language; the practitioners did not know the Arabic names. Other Arabic speakers had no idea about the Fūr names, of course. It is essential to know the Arabic name in order to be able to determine the botanical name, to carry out further research on the great array of the Fūr pharmacopoeia. Linguistic difficulties could be overcome with more time for research, especially if the research were to be concentrated in this field. After all, the practitioners did know that my own research could not be so specific and was limited mainly to the sociological aspect of medicine in Darfur. However, I believe that they would be willing to participate in a study of their roots and other plant materials if it were to be carried out by an expert - either a botanist or a pharmacologist, perhaps. This is a vast field for investigation and the Fūr experts would appreciate interest from other experts.

7.6 THE HOME THERAPIST

From personal observation it seems that much of the elementary treatment of sickness falls to the hands of women. Almost every woman who has her own family has a number of remedies which she uses if she or her children fall sick. These remedies are most likely passed on to her from her mother or grandmother or perhaps from an aunt. Some women also, occasionally, treat their kinfolk.

The types of treatment given by home therapists are very varied, ranging from plant decoctions to massage and manipulative techniques and minor surgical operations. One factor which is constant among home therapists is that they do not consider themselves to be healers as such, and in the majority of cases do not receive any form of payment.

7.6.1 Biographical sketches

Fatima is a rural Fūr mother, living in a tiny village. She knows a number of treatments for the ailments of childhood, including one for diarrhoea of children and when visited had recently been treating her children and others of her family. On questioning, however, she denied that she was a healer as such and stressed that what she had done was 'what every woman does'. On this occasion she had also given her root remedy to a number of related children but had not been given any sort of payment, although she had been asked to treat them by their mothers. She did not expect to receive payment for what she considered to be a normal response to a sick child, equating her action with that of giving water to a thirsty child.

Zahra, an older woman whose family is already grown up, is still called upon by her kinswomen to treat their children for coughs and breathing problems, especially when the child refuses to feed. Zahra learnt about childhood diseases from her two grandmothers who were well-known for their home therapies it seems. She also does not accept payment for her treatments as a rule, but might accept a gift of sugar or tea from a non-kinsman.

Hajja is now a widow and lives on her own. She has pain in her knees and makes herself a kind of poultice which she wraps around her knees. She learned a number of remedies when she was a child. According to her, everyone learned to treat the common ailments when she was a young girl and these remedies were passed down in the family. This practice seems to have almost died out nowadays because, as she says 'people just go to the doctor for medicines'. Hajja says that she would prefer to try to treat a child herself, but if she failed she would take the child to the doctor.

Amna lives in a small village in Jebel Marra. If her children become sick she collects roots to make a decoction for them and adds miḥaya to this (which she obtains from an old woman in her village). She knows a number of other remedies for painful joints and stomach troubles.

In common with mothers everywhere, Fūr women give treatments to their families along the lines of what might be called 'domestic first aid'. They do not usually set out to heal others, but would probably not refuse to do so. They would be very reluctant to accept any payment for what they consider to be part of every woman's duty to her immediate family and anyone else who needed help.

Felkin records that 'when ill Fors are well looked after', (Felkin, 1885:258). At such times some elderly women were sent for and they looked after the sick in their houses, sometimes in an area specially partitioned off from the rest of the house. Those with smallpox were treated in isolation. He also records that the Fūr possessed a good knowledge of bark, roots and leaves, which they gathered and stored in horns and jars, a decoction being made when required, (*ibid*). Here, then, in the person of the home therapist is the concept of the wise woman, practical and pragmatic, taking care of those around her and their day to day diseases.

7.6.2 Techniques of treatment used by home therapists

Home therapists as a category of healer, do not have any techniques of healing which are unique to them, although there are certain treatments which are often utilized by women, to treat the members of their families. These treatments are either in the nature of first aid, such as when a child is burnt or has a wound, or are for ailments which are considered to be trivial.

The majority of women have knowledge of a number of medicines which are made of common and easily obtainable plant materials such as the fruits of the dei, (F.) (hijlij, Ar.; Balanites aegyptica, L.) eaten for relief of osūra (constipation); an infusion of the bark of the numang (F.) (nabaq, Ar.; Ziziphus spinachristi, L.) taken for abdominal pain; a decoction of the leaves of guava, which soothes a colicky pain; an infusion of the white powder from the inside of the fruit of the maada (F.) (tebeldi, Ar.; Adansonia digitata, L.).

For aches and pains, commonly known as ratūba (which is probably similar to our 'rheumatism') dry poultices of heated leaves are applied to the affected part or hot smoke baths are taken. Wood from certain trees which burns with a pleasant perfume, is used for this purpose. For such a smoke bath, the individual rubs his or her body with a perfumed oil or the home therapist may assist and then sits near or over the hole in the ground (which is designed for this purpose to take the embers and the wood) on a small stool, wrapped in a thick blanket. The individual should remain in this position for 30-40 minutes, until the sweating stops, and should repeat the treatment two or three times a day for three to four days.

Massage using a perfumed paste (dilka) is a particularly soothing treatment for aches and pains and general tiredness. The base of this mixture is sorghum flour (dhurra) and fragrant oils and perfumes are mixed with it and the mixture is pressed onto a large wooden plate and inverted over a slowly burning fire of taari (tulih, Ar.; Acacia seyal, L.) wood, which gives a fragrant smoke, for three or four days; it is then rounded into small balls to be kept. To use, a ball of dilka is softened with perfumed oil and then massaged into the body until it rubs off, leaving the skin smooth and supple and fragrant. This treatment is appreciated for its relaxing quality as well as for relief of aches and pains.

If a child is burnt, the first aid treatment may be to wash the burn with human urine and/or to apply a thin mixture of millet flour and water (ajīn, Ar.). For ailments such as coughs and colds, the red sepals of karkadeh (Hibiscus sabdariffa, L.) or the pods of feteng or saye fata (F.)

(sunt or garad, Ar.; Acacia arabica or A.nilotica, L.) may be boiled and the decoction drunk, with or without sugar. A mixture of the two may also be taken. Karkadeh may also be made as an infusion by soaking the dried sepals for some time in water.

Many of these remedies are known by the majority of people, both men and women, though it is usually women who actually carry out or give the treatment. Men who like to treat themselves prefer to make their own miḥaya.

7.7 PROPHYLACTICS AND THERAPEUTICS OF THE OWNER OF ROOTS AND THE HOME THERAPIST

Plant materials and their medicinal uses by the Fūr are to be found in Appendix 3 but a number of plant materials, which it was possible to observe, are mentioned here together with some intrinsic characteristics of the plants themselves which seem to feature in the rationale for their use.

Millet is one of the most important elements in Fūr life and is used medicinally and ritually in addition to its main nutritional use. The ritual use would seem to have decreased, following the death of Sultan Ali Dinar and the gradual falling into disuse of the rituals associated with the divine kingship.

Millet flour is made into porridge,¹ beer,² pancakes³ and a nourishing gruel⁴ to which sugar and milk are added. This gruel, which may be thick

1. porridge - nung (F.), asīda (Ar.).

2. beer - kera (F.), merīsa (Ar.).

3. pancakes - tugur (F.), guraṣa/quraṣa (Ar.).

4. gruel - durri (F.), nisha (Ar.). In the areas of fieldwork both Fūr and Arabic names were used for these food substances.

or thin, is used in the treatment of dysentāriya and is also given to those who are recuperating from any debilitating sickness. An uncooked mixture of flour and water is used for covering burns and a similar mixture is sprayed over boys awaiting circumcision by their female kin, who chant 'bora futa, bora futa' ('milk-white') as they do so. Certain sacred rocks and trees associated with snakes and rain-making were also sprayed with this mixture during the various rituals held in connection with them, according to aged informants.

Apart from its beneficial medicinal properties as an anti-diarrhoeal, the intrinsic whiteness of the flour and various food substances made with it, adds a mystical influence. According to informants, bora futa corresponds to 'mother's milk' and embraces ideas of goodness and sustenance. (Whiteness and goodness are linked again in the term 'kilma futa', 'white heart', used to describe a good, kindly, sympathetic and honourable person.) A number of other white or whitish plant materials are also used for problems associated with the digestive system. The white powdery substance inside the fruit of the tebelidi and the white roots of gumorgo (F.) may both be mixed with milk or water as a medicinal drink. Thus, white substances as materia medica may be seen as analogous to the goodness, kindness and nurture of motherhood and mother's milk.¹

Penicillin, a popular injection, is white - a white powder which is dissolved in water to form a white injectable liquid. The fact that penicillin is normally known and taken as an injection in Sudan undoubtedly potentiates its possibilities for healing, as it is seen to be administered directly into the body.

1. Haaland also notes the use of the flour and water mixture and its connection with 'mother's milk' (Haaland, G, 'Economic Allocations and Symbolic Structures in a Fur Society', DERAP (Seminar paper.)

Whiteness as food gives life, as medicine it provides comfort, remedy and restitution. The soothing and protective powers of the flour and water mixture are utilized in the treatment of burns, when the burnt area is covered with the mixture. As a ritual substance the flour, mixed with water, gives prophylaxis and protection as in the case of the boys awaiting circumcision in their mothers' cottages. This is a time of transition, and the white mixture promises a straightforward recovery from the operation.

Another instance of whiteness is seen in the bayaḍ, the traditional opening payment made to a feqi. The bayaḍ is discussed on pp.280-281.

Many of the roots observed were reddish in colour or red-brown. Irigenar (F.) (iriq el-nār, Ar., possibly Waltheria indica, L.) is a red scaly root, said to resemble the skin of a crocodile, which forms a sour decoction. The pods of Acacia arabica and the sepals of Hibiscus sabdariffa also give red-brown and deep red decoctions, made more palatable with the addition of sugar. All three decoctions possibly potentiated by the heat of their preparation, are used in the treatment of coughs and colds. A decoction of the roots of tibir (F.) a red bush growing in Jebel Marra, is used in the treatment of diarrhoea.

Hot red pepper is consumed in quantity in Darfur and throughout Sudan. However, if an individual has enjoyed an excess of alcohol the previous evening, in order to counter the symptoms of inebriation he will request raw liver (also red) for his breakfast and eat it liberally spiced with pepper.

Red, it seems is analogous to health and well-being. The red cord (jertig) worn around the wrist at weddings by the bride and groom and by the boys undergoing circumcision, is regarded as a good omen or talisman, signifying the auspicious occasion and hopes for future health and prosperity. When materia medica are red, this intrinsic feature of colour may be seen as symbolic of the well-being that the medicine brings to the sufferer. Such medicines are often injected, thus internalizing their propitious qualities.

Although the staple food of the Fūr is whitish in colour, with all that that signifies, the spicy meat sauce or relish which is served with the porridge is reddish in colour, due to the pounded red peppers liberally added. Thus, the Fūr daily partake of a meal that is life-giving and comforting, assuring them of well-being.

The symbolism in some ways bears a resemblance to that which Turner has analysed in Lunda medicine (Turner, 1967c.). However, in the Fūr case, the symbolism seems not to be experienced so explicitly or so elaborately; it is indeed, a much paler form of symbolism.

Occasionally, plant materials are required to impart their beneficial qualities externally. An infusion of the pods of Acacia arabica is used to bathe a premature baby in order to 'thicken' the delicate skin. These pods have a thick wall and form a good protective case for the seeds within, a property no doubt wished to be transferred to the new baby's skin. The reddish-brown colour of the bathing liquid is probably also a feature of the rationale of its use.

Shape may be a quality which inspires the use of plant (and other) materials in medicine. The thorns of a number of species of *Acacia* are used in the treatment of sickness caused by the evil eye, in order to 'spike' the eye. The thorns are cut into small pieces and placed in miḥaya especially prepared for the victim to drink. This treatment may be enhanced by the use of a red-hot axe, which is cooled by immersion in the miḥaya and then applied to various parts of the anatomy of the sufferer. After this, the remains of the thorns are burnt and the ashes added to a second miḥaya, with which the victim of the evil eye bathes. This bathing takes place at the site of an ants' nest, during the day-time if possible but must not be witnessed.

The somewhat oily fruits of *Balanites aegyptica* are chewed for relief of constipation. If the problem is a chronic one, one fruit may be chewed each morning, in the hope that the consistency of the fruit may be transferred to the stools. In the case of the reverse problem, when the flour and water mixture are cooked to make the gruel for treating diarrhoeal problems, the thickening property of the mixture when boiled must also enhance its healing potential.

Fragrant perfumes obtained from aromatic woods or from animal products such as ambergris and musk, are frequently used in prophylactic and therapeutic techniques by home therapists and also by feqis, occasionally. Such perfumes are believed to keep away evil spirits who fear beautiful perfumes, favouring the malodorous 'stinks' of putrefaction and decay.

For the warm poultice of leaves made for ratūba, it is the leaves of the nīm (Ar.), Azadirachta indica, L.) which are used. Ratūba, aches and pains particularly in the joints, is probably similar to 'rheumatism' and is associated with dampness and humidity. The leaves of the nīm are somewhat unusual in that they fall during the rainy season and are thus associated with dryness and warmth, when they flourish and the tree is rejuvenated. Such qualities would be desired of those with ratūba.

Another treatment associated with leaves is that of dogga (F.) an ailment of newly born babies. During the first week of life, if a baby refuses to feed and trembles but does not cry, it is said to be suffering dogga, another feature of which is a blue-green colouration of the abdomen. To treat, the baby is placed on the flat stone used for making pancakes, which is called dogga, lying on leaves of Calotropis procea (L.), the Dead Sea apple. These leaves are quite large and roundish and of a blue-green colour. Seven leaves in all are used, some under the baby and the rest are used as a cover. Each leaf is then thrown away separately from the baby and recovery occurs. Here are seen three therapeutic factors in the one treatment: the stone on which the child is laid is associated with the making of foodstuffs from the staple, millet, and its associations with maternal characteristics; the blue-green of the leaves is echoed by the tinge of the baby's abdomen and these leaves are ritually thrown away one by one, as the sickness should be discarded by the baby's body; seven leaves are used, one of the traditional ritual numbers frequently used in therapy and prophylaxis, notably by feqis, spirit healers and diviners, as mentioned previously, page 333, Chapter 7. The massage

treatment using dilka has a number of qualities which would ensure its appreciation by the Fūr. The perfumed paste has as its base sorghum flour, dhurra, also whitish in colour and the other main staple in the diet; it is grown more on the lower slopes of the mountain and in the lowlands. As a white flour it is imbued with similar qualities of motherhood to those associated with the millet flour mentioned earlier. Also, the fact that the massage requires direct physical contact by the hands of the home therapist means that the goodness of motherly care and love is directly felt by the sufferer as a 'laying on of hands'. The external smoothing of the skin, due to the slightly abrasive character of the dilka, and the relief of aches and pains which results from the pressure and relaxation of pressure applied by the hands is easily interpreted as an internal soothing and smoothing of the rather jagged feeling of moving flesh and joints when they are tender.

The warming quality of smoke baths also helps in the relief of aches and pains and, in addition, the smoke can be seen to envelop the whole body. However, it is most likely that in this treatment, it is the perfume of the burning wood which is the important aspect of its healing character. This is also a feature of the dilka, due to the perfumed oils which are added to the base of flour.

Where poultices are applied, their ability to 'draw out' the pus of a painful boil by heating the part may be analogous to cooking the boil until it literally 'boils over' and the pain is drawn out. Thus, if pain and pus can be removed in this method, it is also feasible that pain alone can also be drawn out of joints and muscles.

7.8 THE BASĪR¹

A basīr is much more than just a bone-setter, for he not only reduces dislocations and fractures and applies splintage for such traumata but also is skilled in other techniques such as cauterization, cupping, cutting and soft tissue manipulation. Occasionally, sleight of hand is used when 'bones' and 'worms' are removed from various portions of the client's anatomy, which would prevent recovery; after their removal, there is nothing to hinder complete rehabilitation. The basīr is, traditionally, the practitioner most frequently consulted in cases of venereal disease. In the majority of cases, the basīr is a blacksmith, or at least descended from a family of blacksmiths, which in Darfur also means that he is usually a Tama whose family has long-standing connections with the Fūr. The majority of blacksmiths seem to practice as basīrs at one time or another.

In the urban situation, blacksmiths tend to live on the outskirts of town, in a neighbourhood traditionally associated with craftsmen, or they may work in the market (towards the periphery) and live on the very edge of the habitation. Blacksmiths who live in rural areas tend to live at a slight distance from the main clusters of houses. It is usual to find only one Tama family in association with a village or urban neighbourhood.

The skills of the blacksmith are almost always passed on from father to son; the son begins to work with his father from an early age, at first working the bellows and progressing slowly to working with metal, making

1. basīr (Ar. coll.) - literally, 'one who has insight' or 'one who has knowledge of what is inside', from baṣīr (Ar.)

and mending farming implements. Sons tend to stay with their fathers until the old men die or have to retire because they become incapable of working. Two of the blacksmiths interviewed were well over 80 years of age and could have been approaching 90 years,¹ but were still running the business and were still training their sons (who were well into their 50's) in the crafts of the blacksmith and the art of healing. The two trainings tend to run concurrently and each is almost a life-long pursuit.

7.8.1 Biographical sketches

Abd el-Latīf, the one basīr interviewed who was not a blacksmith, studied the Qur'an as a young boy and attended elementary school. He was then apprenticed as a mechanic and now works for a government agricultural scheme. He claims to be a firm believer in the benefit to be gained from modern medicine but recalls how he (as a boy) watched his father and grandfather treating people suffering a variety of complaints, and relieving their symptoms. This occurred in a village far from the nearest modern medical treatment centre, some 30 years prior to the interview. As a young man, Abd el-Latīf decided to learn all he could from his father and grandfather, in case he was ever to be in need of such skills or was in a position to assist others. As he said, 'in far villages there is no alternative to country medicine', although even at the time of fieldwork this situation was changing as more young community health workers complete their training and return to their home areas.

1. From my own calculations of their age, according to their childhood or teenage memories of historical events.

According to Abd el-Latīf, he spent only a few months learning the techniques of therapy used by his father and grandfather, but his knowledge of sickness and injuries and their treatment, and also of anatomy, are quite considerable. Presumably, he has retained much of what he observed regarding diagnosis and techniques of treatment from the time of his childhood. His treatments range from those for acute and chronic ulcers, swellings, abdominal disturbances, ear and eye complaints and contractures following burns to those for traumatic injuries and venereal diseases. Not all basīrs have quite such a wide range of therapies.

Abd el-Latīf himself prefers to consult a practitioner of modern medicine and is keen for others to do likewise. However, if he finds people who are sick in the villages he visits during the course of his work, he is prepared to treat them.

Nūr el-Dīn is a Tama blacksmith who reckons he is well over 80 years old; he certainly looks very old and is now capable of only a very little work each day, mainly instructing his apprentice, one of his sons. He attended Qur'an school and served his apprenticeship with his father, but managed to go to the Nuba mountains for three years as a young man to learn more about healing techniques. He sometimes adds certain roots to his treatments and, occasionally, miḥaya.

Within the walls of Nūr el-Dīn's homestead it is not uncommon to see one or two discarded plaster of Paris casts, which he has removed from individuals who have previously been treated in hospital. Such people ask him to remove these casts either because they become uncomfortable in

the early hours or days after application or after several weeks, when the pain and swelling of the injury have subsided, and they have become tired of wearing the restrictive splint. Nūr el-Dīn removes plaster casts by hacking at them with a knife until they are soft and weak enough to be torn by hand. After removing a new cast, he rubs the fracture site with ostrich fat and then applies a short traditional splint for ten days, when he examines the limb again. For a lower limb fracture, the injured person must rest and not put weight through the limb. After checking the position of the limb after ten days, Nūr el-Dīn re-applies the traditional splint and this is worn until at least four weeks have passed since the injury. He then asks the individual to stand and put weight through the limb and to walk on it. If this operation is performed without problem, the limb is considered healed; if not the splint is re-applied for a further week and re-assessed. If he is the first to treat a fracture, Nūr el-Dīn applies his traditional splint for two or four weeks (for upper and lower limb fractures, respectively), but may inspect the limb during this time.

The services of an urban basīr like Nūr el-Dīn have become very expensive in recent years apparently. Some practitioners ask for the payment before they treat the individual and this may be as high as £5. Those who do not have enough money to pay in advance, Nūr el-Dīn advises to go to the hospital.

Sulayman is another very old Tama blacksmith. He worked for seven years for Sultan Ali Dinar as a blacksmith and, thus, must also be in his 80's. Sulayman works under an ancient shade roof in a tiny hamlet not far from the edge of town, with his son, his small grandson who works the

bellows and another apprentice. He is an expert in the making of knives (of the type which all rural Sudanese men wear when they dress in jellabiya and imma - the traditional flowing robe and turban). Such a knife is worn on the left arm above the elbow, in a leather sheath attached to an arm band and is covered by the loose sleeve of the jellabiya. Sulayman also repairs guns and farming implements.

Sulayman, it is said, uses thunder and lightning in his treatments, although he denies this while admitting that 'others may do so'. His practice is a flourishing one and many people come to consult him while he repairs an implement or sharpens a knife. Both men and women seek his help, amid the ringing of beaten metal, around the forge.

The fact that he is always to be found makes the rural blacksmith a popular choice of healer. He has a fixed place of work known to all and is not absent at any time due to farming activities and he lives and sleeps more or less next door to his forge.

7.8.2 Techniques of treatment of the basīr

Bone-setting in Darfur is only one of a variety of physical treatments in which the basīr is skilled; other treatments include soft tissue manipulation, cupping, cutting and cautery, and uvulectomy.

The reduction of fractures by the basīr is carried out by the use of traction on the distal end of the affected limb and then the application of a short splint made from a number of pieces of wood connected together with strips of leather, cotton material or other string-like substance. This is secured tightly around the fracture site, over some cotton wool or

material for padding. The splint is usually not more than 20cm. long, shorter for a child. The joints above and below the fracture are not immobilized. A basīr likes to remove the splint after a day or two to check that alignment of the two bone ends is satisfactory and also to check on swelling. If satisfied he will then replace the splint for about two weeks for the upper limb and for four weeks to 40 days for the lower limb. During this time the limb should be kept still and the sufferer should rest and take nourishing food such as chicken soup and meat and the nourishing nisha made from millet flour and sugar.

There is a difference of opinion among bone-setters as to the correct length of time for an individual, who has a lower limb fracture, to be non-weight-bearing. Some say that weight-bearing should begin immediately after the splint is removed, i.e. after four weeks to 40 days, others say that it should be soon after this time, while one or two insisted that weight-bearing could begin immediately the splint had been applied, without the period of rest.

One basīr claimed to have produced a mixture from flour, salt and water which, he said, gave a splint similar to that of 'gyps' (plaster of Paris). His splint 'allowed the blood to flow and prevented swelling'. Another bone-setter used a round piece of dried gourd, strapped to the chest wall to prevent movement of bone ends when ribs had been fractured. For a fractured clavicle, a small bag of grain is tied under the arm to take some of the weight of the limb.

Manipulation of joints and soft tissues for aches and pains, is a skill of many basīrs. The joints are usually moved to the limits of their

range and just a fraction further to gain a loud cracking sound - indicative of a good treatment, according to both healer and sufferer. Soft tissues are manipulated with forceful manoeuvres, pressings and squeezings.

Cupping is usually performed in association with cutting, especially when a swelling such as an abscess, is being treated, although it may be performed on its own for headaches and chest troubles. Cupping is usually and traditionally performed with a cow's horn which is heated and quickly applied to the skin over the affected part. As the horn cools, the air inside it contracts and so pulls the flesh upwards into the horn. This is said to encourage an abscess to erupt and if cutting is also performed at the right time, will draw the infected material out of the tissues. Cupping may be used for its counter-irritant effect, especially where pain is present, for it leaves a circular burn on the surface of the skin.

If a basīr is asked to treat an abscess, haematoma or other swelling which appears to be of a fluid nature, he will most likely incise the surface of the swelling before applying his cupping horn. In this instance, he may decide to use the horn in a different way - as a vacuum. The tip of the horn is removed and a piece of clay is put over the hole. The clay is held in the mouth of the operator as he applies the horn, holding it firmly onto the affected part; the basīr then applies suction to the horn and covers the hole with the clay. The negative pressure inside the horn encourages the escape of blood, pus or serous fluid from the swelling.

Cutting may be carried out without cupping; it is most commonly seen on the abdomen, especially of a baby, if the child is diagnosed as having



7. SCARS OF CAUTERY - USED IN TREATMENT
OF JAUNDICE

some stomach troubles with distended abdomen. The abdomen is then snicked over the entire surface with a razor blade, producing tiny incisions. Cutting is also carried out if it is suspected that a small child has some vision defect or other eye problem. Two or three small vertical cuts are made near to the outer corners of the eyes.

Cautery is a much favoured therapy in Darfur and it is performed for a variety of problems from headache to jaundice. For this operation, a large nail or other like-shaped metal object is placed in the fire to become red-hot. When red-hot, the nail is taken from the fire and touched on the skin, usually in two places side by side, at the points deemed suitable by the basīr. Several places may need to be treated, as in the case of jaundice when the upper arms, abdomen around the umbilicus, heels and back of the neck may be cauterized. If an infant is having teething problems, the gums where the teeth are erupting are cauterized.¹

Uvulectomy is performed if a child suffers persistent diarrhoea, which is believed to be caused by a uvula which is too long. An instrument like an old-fashioned button-hook, but with a sharp inner edge to the hook, is used to remove the uvula.

7.9 THERAPEUTICS OF THE BASĪR

Blacksmiths are recognized in Darfur, as in other societies, as being powerful individuals. This is most likely connected with their ability to deal with dangerous and powerful elements such as fire and iron and

1. Cautery is the treatment of which the Prophet Muhammed specifically disapproved (see Chapter 2:69) see photograph 7.

to transform the metal into implements, tools and weapons. As the 'transformer' of the metal into useful objects, the blacksmith has a liminal position. He also lives liminally, with his family, on the periphery of the community to which he is associated.

The blacksmith-basīr in Darfur is believed to be able to harness the forces of nature, particularly thunder and lightning, and to be able to use them in the healing process, or in other ways; it is said that such individuals can (and do) cause harm to certain individuals through these forces if they so wish. An individual wishing to harm another may be able to enlist the assistance of a blacksmith in his venture (with a sizeable payment in advance).

The basīr is mainly concerned with therapy, rather than any prophylactic measures and it is his own person which attaches significance to his treatments. He can reform metal and direct the forces of nature and thus, he is associated with change. When he applies metal in his treatment, particularly hot metal as in the case of cautery, or sharp metal in the case of cutting, a change (hopefully for the better) is almost guaranteed.

The firm splintage on the outside of the fractured limb emphasizes the firmness which should be transferred to the inner broken structures, a process which is begun by the use of the strong hands of the basīr in manipulating the broken ends into the line of the undamaged limb.

7.10 THE ROPE-MIDWIFE¹

The rope-midwife (dayat el-ḥabil) whose name comes from the rope (ḥabil) suspended from the roof of the cottage, with which the woman giving birth supports herself, is always a woman and usually one who has had children herself; she is not necessarily an elderly woman. The rope-midwife works in the village where she lives and, thus, knows the women and is known by them; she may also be related to a majority of them. Rope-midwives tend to be the daughters of rope-midwives, thus keeping the skills of midwifery within certain families.

As hospital births are still uncommon in Darfur, the women are not accustomed to giving birth lying on a bed. They prefer to be free to walk about or to stand and lean against a wall. While the baby is actually being born, the woman kneels down, resting back on her heels and supports herself by holding on to the rope suspended from the ceiling.

The rope-midwife looks after the mother and newborn baby for seven days, if possible, washing and feeding the mother and washing the baby. This period of time spent looking after the mother is much appreciated by Fūr women because it is probably the only time a woman has any relief from the normal tough routine activities of any Fūr farmer-housewife. A hospital birth or one attended by the modern medical midwife gives the new mother only four days respite before she must resume her daily activities.

Among the hardworking the physically strong Fūr women farmers pregnancy, like menstruation, is a sign of health. Labour, even when it

1. The rope-midwife is known by a number of names in Darfur - dayat el-ḥabil is probably the most common, even among the Fūr, but kamurr (F.) and walada (Ar.) are also used.

is long, is not regarded as anything other than the normal course of events. Indeed it is not unknown for the pregnant woman to be on her farm when labour starts. The rope-midwife is called - she may be in a nearby field - and the birth takes place on the farm, perhaps in one of the small cottages built for sheltering from the rain. After an hour or two, the new mother can walk home with her baby. With such a 'natural' birth being a possibility, Fūr women regard it as 'good sense' to be able to call the midwife when she is needed rather than to take an unnecessary amount of time off to go to sit in hospital to await the birth; it would be too far for any pregnant mother to travel to hospital after labour had started, the baby would be born en route. They would be grateful for easier access to modern medical assistance, however, for the few births that do require more skill and knowledge than that possessed by the rope-midwife. Apart from these occasions (which they assured me were very rare), they prefer to be among the women they know, at home.

At the time of fieldwork, a number of women had experienced a birth attended by the modern medical midwife, herself the daughter of a rope-midwife. The women generally thought that such a compromise was good, for here was the next generation of rope-midwives, who doubtless knew their mothers' techniques, but who had the additional skills of modern medicine. The women were in favour of pre-natal check-ups because, according to them, miscarriages in the early weeks of pregnancy are more common than labour difficulties and present more problems. They also mean that the woman cannot undertake her farming activities and look after

her animals as she would wish to. (Perhaps it should be stressed here that it is the wish of the women themselves to be independent rather than any unwillingness to help one another.)

7.10.1 Biographical sketches

Nafisa is a rope-midwife and was 37 years old when interviewed. She has six children herself and is also a grandmother; her last child is a few months younger than her grandchild. She is not a Fūr but speaks enough of the Fūr language to converse with elderly Fūr women who speak no Arabic. Nafisa lives among the Fūr, has a small farm, some chickens and two cows and also works in the hospital as an orderly. She attended Qur'an school as a young girl and although she had no other form of education, is very well informed about what is going on in Sudan generally, about education and health. She listens to the news broadcasts and is actively interested in her sons' schooling. Thus, in many ways she is an unusual woman in this part of Sudan, for normally it is only men and the few secondary school educated girls who would show any interest in anything outside the home and the farm.

Nafisa has delivered more than 20 babies and claims that she has experienced no problems. When interviewed she had recently delivered her own grandchild, but apart from this she has given up the practice, partly because she does not have enough time but also because she wants to be more 'modern' and to encourage people to use the services supplied by the state. She has here been influenced by the fact that while working in the hospital, she has seen a number of women experiencing

labour difficulties (from which they were not expected to survive) successfully operated upon by the medical officer.

Although, when she used to act as a rope-midwife, she did not ask for payment, Nafisa was used to accepting a gift. Such gifts were usually in the form of sugar and soap - luxury items in Darfur.

When she is sick herself, Nafisa consults a practitioner of modern medicine and also encourages her children to do the same. She quite often accompanies her kinfolk and friends to consult a practitioner of modern medicine and her advice is frequently sought because of her contacts within the field of modern medicine.

Another rope-midwife is Keltūm. She is about 40 years old, a housewife and farmer and the mother of five boys. She goes to work on her farm, some few kilometres from her home, every day during the farming season but when needed for a birth is able to get one of her children to help with the farming. At other times of the year she is less busy and able to cope easily with births. She has delivered over 40 babies.

Keltūm denies that she learnt her skills as a midwife from her mother, or any other kinswoman. She maintains that her skill comes entirely 'min Allah' (from God). Keltūm had no education in her childhood, she did not attend Qur'an school either. She does not ask for payment for her midwifery skills but is also presented with a gift of some luxury item after the birth. When she feels unwell herself, Keltūm consults a practitioner of modern medicine, 'for an injection'.

7.10.2 Rope-midwifery

The rope-midwife (daiyat el-ḥabil) goes to the house of the expectant mother when labour has begun. She palpates the abdomen and determines when the baby will be born. When the time is almost right for the delivery, the midwife positions the mother kneeling with her knees apart and holding a rope suspended from the roof. Another woman, usually her mother or another relative, supports the mother from behind. From in front of the mother (and under the wrapper or tōb) the rope-midwife washes the perineum and, if the mother has been pharaonically circumcised (not so common among the Fūr), she makes two incisions at right angles to the circumcision scar, in order to extract the baby. She then helps the baby out and ties the cord in two places when the placenta has been delivered, and cuts the cord. She clears the baby's mouth of secretions and if it does not cry, smacks its abdomen.

The rope-midwife then washes the mother with warm water and cleans the perineum with hot water and oil. She does not attempt any sewing of the incision but repeats the washing for two days. Immediately the mother is comfortable she is given the baby to feed. If the baby does not suck well, a little sugar or salt is put on its lips and tongue to promote sucking. The rope-midwife attends the mother for about seven days usually.

7.11 THE EYE PRACTITIONER

Practitioners who operate on the eye are usually Fellata (West African immigrants who are making their way to or from Mecca) and are relatively

few in number in comparison with other healers. They are usually travelling and do not remain in one place for more than a few days. However, there are also a few Fūr practitioners, known as shallangi, who perform similar operations. They also tend to travel about the country, setting up a brief practice in a number of urban centres where they have a relative or friend.

Only one Fellata practitioner was encountered during fieldwork, and then only briefly. No operation was witnessed. However, their work is well known and several accounts from informants in different parts of Darfur were almost identical. One elderly woman informant had been operated on by a Fūr practitioner and was able to see to her satisfaction two years later.

Eye practitioners are almost always male. No account was given of a female practitioner. They usually learn their skills from a male relative (father or father's brother) or are apprentices, occasionally, to an unrelated practitioner for a short time. They have set charges for each type of operation and payment is made at the time of operation. The charge for such an operation is usually very high, about £\$15-20 or more, at the time of fieldwork.

7.11.1 Surgical procedures performed on the eyes

The Fellata are known throughout Sudan for the operation, called tashlīq, which they perform for opacity of the lens of the eye. A similar procedure is carried out by a few Fūr practitioners known as shallangi. These practitioners also perform other surgical operations upon the eyes - for corneal opacity and trachoma.

Shallangi operate with a needle, which they first hold in a flame and then, kneeling astride the motionless sufferer, they push the lens into the posterior chamber of the eye, so giving an immediate improvement in sight (though some problem with focussing).

Fūr practitioners who operate on opacity of the cornea use an instrument which looks somewhat like a scalpel (called a fallang) which is used to raise the edge of the cornea, the whole surface of which is then dusted with powdered roots and bandaged for seven days. After this time, the bandages are undone and the cornea, which has dried up, will come away from the front of the eye with ease, thus giving at least a temporary improvement in sight.

For the granulations which occur on the inner surfaces of the eyelids in trachoma, the practitioner may use the leg of a locust, which has tiny claw-like projections and can be rubbed over the granulations to reduce them; it is however only a temporary measure as is the rubbing of charcoal and naṭrūn (naturally occurring sesquicarbonate of soda) over the granulations. Sometimes the appetizer kawal¹ may be rubbed over the eyelids after the granulations have been made to bleed. Kawal is perhaps used in the hope that its smooth slipperiness may be imparted to the eyelids, where before they were gritty and painful.

1. kawal is made from the leaves of Cleome viscosa, (L.) which are kept in water for a week, before drying in the sun as black balls, which have a very strong smell of methane. In Darfur this is powdered and sprinkled into the food as an appetizer.

7.12 THERAPEUTIC ASPECTS OF ROPE-MIDWIFERY AND EYE SURGERY

The rope-midwife holds a somewhat different position from the practitioners of medicine already described, for she is a wise, skilled expert rather than a ritual specialist. Moreover, she is not concerned with sickness as such, but with health and new life. Fūr women were very positive in their denial of any idea of sickness being attached to pregnancy, labour and birth. They regard the lack of pregnancy with great concern and this may be regarded as sickness.

The wisdom and skills of rope-midwifery, passed on from mother to daughter, are practical and purposeful. There is no ascription to the rope-midwife or to her practice, of any mystical attribute.

Eye practitioners are also regarded as skilled experts, rather than ritual specialists. They usually deal with old people who are nearing the end of their lives and who are suffering the signs and symptoms of advancing years. Loss of sight at this stage of the life-cycle is not regarded strictly as a sickness, although it does not happen to everyone. The elderly person does not feel unwell but will become increasingly handicapped, though this state will be reached gradually.

7.13 THE GENERAL PRACTITIONER OF MEDICINE

There are no healers in Darfur who are expert in all the fields already described, partly because some of the healing techniques are sex specific. For example, no man could act as a rope-midwife and the use of the holy word in healing is almost exclusively limited to male practitioners (with a very few notable exceptions - women only use Cazīma and miḥaya for

themselves and perhaps their children - in any case, they do not act as healers for general consultation in this sphere). The technique of the eye practitioner is known mainly by immigrant Fellata (men) and that of the bone-setter, by blacksmiths (again, men). Despite this, a few practitioners were encountered who practised techniques of at least three other types of practitioner. With such a wide range of therapies at his disposal, it seems suitable to entitle this individual a 'general practitioner of medicine'.

7.13.1 Biographical sketches

Feqi Yusef is such an urban general practitioner of medicine. A small rakūba in front of the various other brick-built rooms and cottages of his homestead forms his treatment centre. His homestead is quite large, allowing a number of camels, horses and donkeys to be tethered while their owners await treatment. He also has a cottage where those being treated may stay for some days, if necessary, with their relatives.

Feqi Yusef is first and foremost, a feqi, a fact attested to by the great number of enamelled bowls and other containers which are everywhere inside his rakūba, awaiting the miḥaya which he is to make for their owners. He has studied many of the old books on magic and healing as well as those written by the early Arab doctors. These have enabled him to gain a wide knowledge of many aspects of healing. He uses roots and other plant materials, often in conjunction with miḥaya and in addition to this, he has a selection of inorganic chemicals which he obtains from Khartoum or Saudi Arabia. These are kept in small bottles or screws of

paper dispersed around the room. Feqi Yusef prefers that people go to the hospital when they have broken bones, but has practised as a basīr and feels that he could help someone who did not want to attend the hospital or if no modern medical help was at hand.

The range of sicknesses and conditions which Feqi Yusef named, as being those which he felt he could treat successfully, is very varied and includes digestive troubles, respiratory conditions and fevers, headaches of different kinds, skin conditions including leprosy, aches and pains, labour (but not the actual birth) problems, mental disturbance, the evil eye and sorcery and physical trauma. Certainly he is widely known and people come to him from afar. His knowledge about modern medicine and modern medical drugs is quite extensive. Sometimes he adds aspirin or kaolin to miḥaya or he adds the modern medical drugs that a client has been given by a medical officer, and thus increases the power of the therapy. He often suggests that people coming to see him might be better off in the hospital. He is, of course, always willing to help if the individual does not wish to consult a practitioner of modern medicine or that modern medicine has not produced a cure.

Abbakr is a well-respected practitioner of country medicine and has extended his range of treatments to include the giving of injections, a much demanded therapy. He is in his early 40's and is a farmer; like all men in rural areas, he attended Qur'an school as a boy and has spent some time living in an urban area. He was much more reticent than most healers to be interviewed and was sometimes to be seen running in the opposite direction when he realized that he was about to be visited.

However, when he was eventually found at home and an explanation was made to him concerning the research, he became a willing and interested informant.

He had learned about roots from his mother's brother, apparently a famous practitioner in a village in the northern part of the Jebel. Abbakr had travelled to this village and had remained with his kinsman for some time in order to learn from him. The old man had himself studied roots from another, unrelated healer living far away. As Abbakr considers himself to be a relatively young man, he has not yet thought about the passing-on of his knowledge.

In the small cottage where he stores his crop of dried tomatoes, okra and onions, he also keeps his small stock of roots for the more common complaints he deals with. Some are kept intact, others are crushed and in tins. On the floor of the cottage is evidence of two other aspects of this healer's skills - his loh, pen and inkpot and a number of bowls for miḥaya, and numerous empty bottles which once contained penicillin powder for injection and the discarded phials of injectable water. On the table is the small metal box containing a syringe and needle (as supplied by UNICEF to practitioners of modern medicine such as nurses, midwives and medical assistants, and which can be sterilised by boiling and then kept within the unopened box.

The people of the area have relied upon Abbakr for some time when they have felt they needed penicillin. The penicillin and injectable water, can be easily purchased in most markets from merchants who travel or who deal with merchants from Chad. The injection is a much favoured method of treatment and Abbakr was taught how to administer injections by

'a friend' (who was perhaps an orderly in a dressing station or dispensary). He does not combine treatment by injection with root treatment but is always willing to combine either with miḥaya. He makes an adjustment in the dosage for children of both injections and roots, according to the size of the child.

The technique for giving injections which has been developed by Abbakr is to wash the syringe and needle in warm or hot water, wipe both on the hem of his jellabiya, assemble the instrument and draw up the drug, adjusting the amount to be given by expelling a small amount upwards. He then administers the injection into the muscular area just below the point of the shoulder on the outer aspect of the arm, squeezing the flesh with his other hand as he introduces the syringe and pronounces 'Bismillah' ('in the name of God').

Another practitioner who specializes in injections is Abd el-Majīd. He visits the villages at intervals to give injections to those who desire them. His appearance and behaviour is somewhat striking in the rural setting of Jebel Marra. He wears a sparkling white jellabiya and turban, carries a small black bag in which are his drugs and syringe, and has an air of great confidence. The drugs in his bag on the day of interview were vitamin B and penicillin injections, sterile water for injection, Dapsone, Valium and Lomofil. Abd el-Majīd also uses roots and maintains that he can cure all skin conditions with these and Dapsone (the drug used for leprosy in modern medical therapy).

My first encounter with this man was in a village in Jebel Marra, when he was about to treat a woman. He was cleaning his syringe in water

which had been boiled for him. He then shook the syringe to expel excess water, assembled it and drew up the injection, adjusting the volume by squirting the syringe upwards, turned back his sleeve and disappeared into the cottage with a flourish to administer the dose to his client. Abd el-Majīd had learned how to give injections from 'a hakīm', he said, 'a long time ago'. The term hakīm, which means 'wise man' is normally given to anyone with a medical training, particularly to medical assistants and nurses but also to any other individuals who assist these practitioners to carry out their work, such as orderlies. Previously, this man had treated people with roots, which he was in a good position to obtain as he travelled a great deal around the mountain villages. He knew people in isolated villages who could help him to find roots for use in the lowlands and he had a number of very powerful remedies. He was also prepared to perform cautery and cutting and would have made miḥaya if requested.

7.13.2 Therapeutic importance of the general practitioner

General practitioners of medicine, though not of great numbers in Darfur at the time of fieldwork, do seem to be securing a niche for themselves as deliverers of modern medicine, even in situations where modern medicines would normally be very difficult to obtain. These practitioners often obtain modern medicines, particularly injectable drugs which are sold, normally, only on production of a prescription written by a medical officer or specialist, via some black-market dealings of stolen goods or illegal importation. However, other practitioners buy the drugs they use

over the counter in pharmacies, as in the case of aspirin, Nivaquin and anti-diarrhoeal tablets which they add to miḥaya.

From the Fūr point of view, such practitioners are a godsend, making possible the desired treatment within a very short space of time without travelling a long way and without 'unnecessary' interrogation. From the point of view of modern medical practitioners, such practitioners are dangerous because they do not know the correct dosage to give, are unaware of any side-effects and cannot read the English or French names and instructions on the packaging of the drugs.

The administration of certain modern medical drugs by injection is the most favoured method of treatment of the Fūr. The sharpness of the needle, the 'hotness' of some drugs as they are injected and the fact that the drugs can be seen and felt going into the flesh, ensure the sufferer that healing power has been brought to bear upon his or her complaint.

7.14 THE PRACTITIONER OF MODERN MEDICINE

Throughout Darfur there are scattered small dressing stations run by community health workers and nurses, with a midwife attached to each, and larger establishments, dispensaries, run by medical assistants with nurses and midwives. These units form the basis of the primary health care scheme. In district headquarters such as Zalingie, there are

small hospitals run by young medical officers (with MB.BS. degrees) and in larger provincial headquarters there are bigger hospitals with consultant physicians and surgeons in the major branches of modern medicine. Working in each hospital are a variety of practitioners of modern medicine apart from the medical officers.

To the ordinary Fūr villager, the medical assistant, the nurse, the pharmacist and a variety of other paramedical staff are hardly differentiated. All such individuals, it is believed, are able to give injections, which is what is expected of a ḥakīm (wise man), the title given to those who have a profession within the modern medical field - apart from the medical officer who is entitled el-daktūr. He is singled out as being different, partly because he is usually a foreigner (to Darfur at least) and is assumed, therefore, not to be able to properly understand the Fūr people and their particular sicknesses in the way that another Darfurian would comprehend them. It is assumed that treatment given by a medical officer would be similar to that of the ḥakīm although it is known that he has a longer training and also that the ḥakīm has to refer to him in the treatment of certain sicknesses and for operative procedures. The ḥakīm is preferred by some individuals because 'he does not ask too many questions' and because he is more easily prepared to administer the desired injection without too much unnecessary fuss (from the client's point of view). One medical assistant encountered was somewhat fraught one morning and, when asked why, replied that the elderly women who had consulted him recently had been to complain to his mother that he was not treating them properly. He had refused to give them

injections and, instead wanted them to take tablets by mouth for their ailments.

Practitioners of modern medicine are trained in various schools and hospitals throughout Sudan. Nurses can train in their local district or provincial hospital for the registered nurse and enrolled nurse qualifications. Experienced senior nurses are selected to train as medical assistants. Secondary school leavers are now training as community health workers and are being placed in their natal villages, or at least within the area of their homes, in the hope of extending primary health care throughout Darfur. Likewise midwives are being trained from particular areas, and will be returned to the home areas to work among their kinswomen and fellow villagers.

There is animosity between some practitioners of modern medicine (mainly surgeons and gynaecologists) and certain specific practitioners of country medicine. Herbalists, basīrs, rope-midwives and eye practitioners have all earned the displeasure of modern medical practitioners as a result of their treatments of individual clients. Children who lose limbs because of splints applied too tightly, women who develop vaginal fistulae because they use packs of plant materials to encourage or discourage pregnancy or to treat various feminine complaints, young mothers who die after or during childbirth because of retained placenta and old people who suffer blindness after an operative procedure for cataract, all add fuel to this particular fire. It sometimes works the other way round too, for someone seemingly fairly healthy but bothered by some nagging discomfort may enter hospital for 'tests' (for confirmation of a malignant growth, though this may not be explained to the

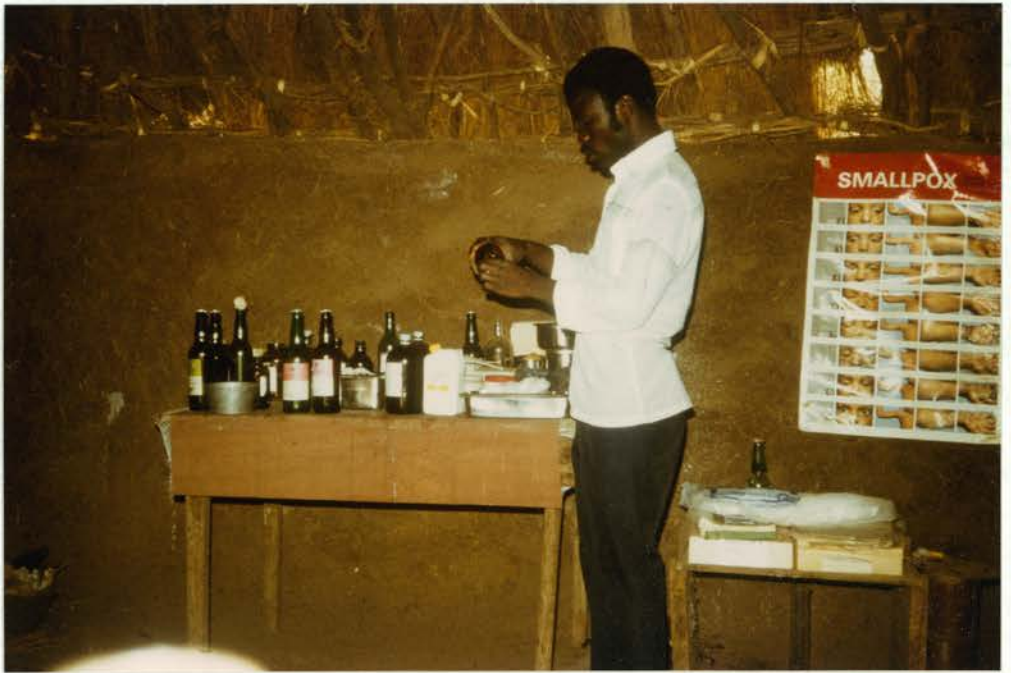
sufferer or to his or her kinfolk) and then very quickly deteriorate. Individuals will question why their healthy kinsman or kinswoman should become so sick while in hospital, when they were not really even complaining of any great discomfort beforehand.

On the other side of the coin are the beneficial results, noted by modern medical informants, of the treatment by the fegi of some emotional problems and symptoms which would be considered to lie in the field of the psychiatrist in modern medicine. A number of practitioners of modern medicine are in favour of developing partnerships with fegis, in particular, realizing their innate qualities which enable them to have a 'finger on the pulse' of their own community. Many practitioners of country medicine consult practitioners of modern medicine when they are sick. Thus, there are many occasions on which good-natured exchanges occur, despite the problems.

7.14.1 Biographical sketches

(i) Abdullahi is a young community health worker. He completed junior secondary school and then found work in the Gezira for several years. On his return to Darfur, applications were being invited for a nine-month course to train community health workers. Abdullahi applied and was selected. He completed his final examinations with good grades and, as he had been an industrious and reliable student, was considered competent to take over the small dressing station in his village. This had been unmanned for some months, since the last nurse left.

Abdullahi was given a supply of drugs and dressings and a few instruments, some bowls, weighing scales and the necessary record books.



8. A COMMUNITY HEALTH WORKER IN A RURAL DRESSING STATION

He contacted a merchant he knew who was travelling to Jebel Marra and all the boxes for the dressing station were loaded on the merchant's lorry for the long drive to the village. Once in the village, the small cottage dressing station was cleaned and its roof repaired, and then Abdullahi was able to open his small treatment centre.

The work Abdullahi carries out is very varied. He may see as many as 20 or as few as 5 sick people at the dressing station in the early morning. He then goes on to visit anyone too ill to go to the dressing station, taking along any drugs and instruments he requires in a briefcase. His home visits may only require him to walk around the village or he may need to travel several kilometres. He also checks the butchery in every market in his area, encouraging the butchers to place their meat on tables rather than the ground, and checking that the meat is good. A community health worker should, whenever possible, attempt to educate the people in his area and encourage them to dig pit latrines and to keep cattle away from the human water supply.

According to Abdullahi, the community health workers hope that after some years experience they will be given the opportunity to continue their study in order to gain promotion. However, there is no higher grade in their particular field at the moment. This problem was also noted by one of the officers in the Ministry of Health who was worried that the young men, who might well be ambitious, interested and good at their jobs, would be tempted to seek higher grades of employment and more money in the Gulf States or Saudi Arabia. This will almost certainly be the case if present conditions of work continue in both Sudan and the Gulf States.

(iii) Until 1928, Darfur was in some degree of turmoil, with numerous small scale political movements and uprisings. It was decided to enhance the occupying presence in Southern Darfur by the building of three forts and they were completed in 1930 - at Nyala, el-Geneina and Zalingie. These forts acted as the seat of administration in the region as well as an army stronghold when necessary.

In 1928, the government sent one of its first-trained medical assistants (Sayyid Usman Muhammed Kheir) to set up and run a small dispensary within the administrative centre at Zalingie. When the administrative offices were fortified in 1930, the dispensary moved to the site of the present Zalingie hospital.

The new dispensary rapidly grew from three small rooms, a theatre and the office of the medical officer, to what amounted to a small hospital, with the addition of three more brick-built wards, kitchen facilities, mortuary and the necessary store-rooms. When there were too many in-patients to be accommodated in the men's and women's wards, as in the time of epidemic disease, the sick lay on the floor of the wards, brought their own beds or were sheltered under shade roofs in the hospital grounds. Male medical and surgical wards and a mixed medical/surgical ward were added, as well as a fever ward at a distance from the other wards. The obstetrics and gynaecology ward is a more recent addition, not being built until the 1950's.

Sayyid Usman, though born in the northern Sudan, found that he liked Zalingie and decided to emigrate. Several members of his family came with him. He was the medical assistant at Zalingie until 1946 and was

then transferred to el-Fasher to become superintendent medical assistant for the Region... Zalingie dispensary continued to be in the hands of a medical assistant until 1955, when the first medical officer was appointed and the dispensary was upgraded to become a hospital.

Nowadays there are several practitioners of modern medicine in private practise in Nyala and el-Fasher, a number of them are specialists. Medical officers in the small district hospitals also run private practices and these are favoured by many people who believe they will get better or more treatment. They may certainly receive more and different drugs from the private clinic as the practitioner supplies these from his own stock - the pharmacy in the hospital may well have run out of certain drugs.

The Zalingie hospital now has its own small nurse training school and takes male and female students. There are six medical assistants in the hospital, running the out-patient department, pharmacy, laboratory and dental clinic. Midwives run the labour ward and also cover home deliveries.

Looking back over the history of the hospital, from its busy days as a dispensary to the present day when it can accommodate 80 patients but has only 40 beds and only about half to three-quarters of these in use at any one time, it would seem that the need for and use of the institution has changed somewhat. Whereas in the early days the majority of admissions were of sufferers of epidemic diseases, today's admissions are mainly emergencies - trauma victims or those needing emergency surgery, and women with labour problems. The small fever ward is hardly ever used - there was one occupant during my fieldwork.

7.15 MODERN MEDICAL DRUG THERAPY

The importance of the general practitioner of medicine and the practitioner of modern medicine, in the view of the Fūr, is in their possession of and ability to administer modern medical drugs. Many of these drugs, and those of particular interest to the Fūr, are in the form of a white injectable solution. Other drugs are in the form of white or whitish tablets, ointments or mixtures, or capsules containing white powders. Tonics and mixtures for coughs and colds often tend to be red or reddish-brown in colour and most have a strong or hot taste. As already mentioned in the discussion on herbal therapeutics, it is often the colour which is the most important feature of the medicinal compound (or liquid) and it is this which assures the sufferer of healing properties. The beneficial qualities of the injectable drugs have already been mentioned, in relation to their administration by the general practitioner of medicine (page 376). Similar properties would be pertinent in the case of similar drugs administered by modern medical practitioners.

Many practitioners of modern medicine are strangers to Darfur; they may come from the capital or from other regions. This applies particularly to medical officers and more senior consultant physicians and surgeons but also occasionally to medical assistants. Until recently, relatively few Darfurians and hardly any Fūr have studied modern medicine in the Faculty of Medicine at the University of Khartoum (or anywhere else). Those who have undertaken this field of study have taken the almost customary step of going abroad for further study and then

taking a highly-paid post in Saudi Arabia or the Gulf States. This means then, that the practitioners of medicine with the most sought after and potent drugs are also strangers - and strangers who practise 'powerful' therapies soon gain a reputation in a rural setting. The general practitioners are often strangers too, although men may make their acquaintance in the market.

The more practical modern medical therapies have not always been received so well by the Fūr. Rope-midwifery and bone-setting still have their strong retainers because both have aspects which the Fūr would rather not experience. Fūr women are disinclined to give birth in the horizontal position which, the modern medical midwives are taught, is the 'best' position for birth and they also are reluctant to forego the longer period of time the rope-midwife is prepared to look after them. As far as bone-setting is concerned, modern medical practitioners require the plaster of Paris splintage to remain on the lower limb for twelve weeks normally (six weeks if the broken bone is non-weight-bearing) and four to six weeks for the upper limb. This seems to be far too long a period of time when considered against that specified by the basīr.

7.16 MEDICINE IN BAREI

The inhabitants of Barei are, on the whole, very devout and earnestly seek to accomplish their religious obligations. Several families are related to the family of the imams of Turra. Many men have the title 'feqi', indicating in this case that they have reached an advanced stage in their

learning of the Qur'an. Five of these fegis are well known as healers, although all would make mihaya and perform Cazīma for themselves and for their wives and children if they became sick. Men also join in a group to write verses of the Qur'an and to perform Cazīma together for a sick individual; such group therapy is often performed in the village. The group meets, usually in the mosque but it could be in a house and each member writes the verses in order that the required thousands of times may be reached more quickly for the sufferer.

There was, at the time of fieldwork, no bone-setting specialist living in Barei itself but one fegi in a nearby village is well known for this practice. Several men and a few women are renowned for their knowledge of roots and other plant materials. One of these women is reputed to be an expert in the treatment of snake bite. The most popular practitioner, however, in the village is probably the general practitioner, although, people did not often mention him during the interviews for the survey schedule. When asked specifically if they had been treated by him, most people replied that they had. This fact was affirmed by the number of discarded phials of penicillin in his small treatment centre. The reluctance of the man himself to be interviewed at first and that of his clients to mention their treatments (which were in the majority successful) is indicative of a knowledge that such therapy is not officially sanctioned (the drugs are obtained on the black market). Secrecy and success have allied in enhancing the power of such therapists.

For more than 40 years (i.e. since the village was established) the only facility for modern medical care within fairly easy reach of Barei has been the small one-cottage dressing station in Daiya. This used to

be staffed by a single nurse, with a modern medical midwife and an orderly until the end of 1979, when the first students of the school of community health workers from this part of Jebel Marra finished their nine-month training. The son of one of the Barei families was sent to take over the dressing station from the nurse. At the same time, another community health worker went to Rokirroh to open a dispensary there. Both these health workers also move around their districts - it is planned that they should receive money to purchase large donkeys to make their rounds easier, at the moment they go on foot; their colleagues in the lowlands have been able to purchase bicycles. Word travels very quickly in the remote districts and when necessary, the health workers can usually be found by a man on a donkey, and they can go to treat anyone in need. Their presence has saved many the need to travel the difficult road to Nyala, el-Fasher or Zalingie.

The drugs and equipment supplied to the dressing stations are basic and consist of mild analgesics, antibiotics, disinfectants for wounds, medicines for the digestive system and for coughs and colds, basic obstetric drugs, intravenous fluids, splints, bandages and dressings etc. As in other markets, some drugs can also be obtained in the market. Even in the tiny market of Barei, one trader had eighteen different drugs for sale quite openly, spread out on the ground in front of him.

7.17 MEDICINE IN AZUMIYA

At the time of fieldwork there were seven religious healers resident in Azumiya, although not always present in the neighbourhood; two were away

in Khartoum¹ throughout the period of fieldwork.

Among the five feqis present during the fieldwork, one was working as a guard at the bank, two were Qur'an school heads and the other two divided their time between their religious and healing activities and their farms. One of these was the brother of a modern medical doctor.

Many men are known to be well versed in the use of root treatments, including some of the feqis. A security guard at an office is also a bone-setter but prefers nowadays that people with broken bones should consult the modern medical practitioner in the hospital. According to his own reckoning he has not treated fractures for about 10 years. Other absentees during fieldwork included a specialist in the treatment of eyes and a bone-setter.

Apparently, people who have some specialist healing skill periodically travel to other centres where they are known, the province capital or further afield, and remain there for some considerable time before returning home. Such a programme, presumably, is beneficial as healers 'from afar' are believed to be powerful. If successful, a good reputation for curing is communicated far and wide, and back to the practitioner's home town or village by travellers and merchants. Thus, the practitioner can keep two thriving practices operational, while at the same time not allowing himself to become too familiar in either setting.

Although there are modern medical midwives living in Azumiya, there are still a few women who act as rope-midwives. One of these women claimed

1. There are several feqis from Darfur living in Khartoum and Omdurman, either in or near to the army barracks. They specialize in making amulets which are reputed to deflect bullets for soldiers.

to have delivered over 40 babies, both in Azumiya and other neighbourhoods. She is certainly well known in Zalingie, particularly in the predominately Fūr areas.

The inhabitants of Azumiya are not limited to consulting the practitioners of modern medicine resident in the neighbourhood; they have a great number to choose from in the rest of Zalingie and in the villages nearby. Travelling practitioners from other parts of Darfūr and Sudan also pass through Zalingie and Azumiya on their 'rounds' of foreign territories. Such practitioners are often West Africans on their way to or from the pilgrimage to Mecca. In the past, a few of these have settled in the town.

Modern medical care, as mentioned previously, is free in Sudan and the inhabitants of Azumiya, Zalingie and the Western District have access to the small district hospital. This combines in-patient care and treatment, with out-patient facilities. There is a pharmacy, a laboratory and basic dental facilities - all run by medical assistants - although there is no X-ray machine. Apart from the hospital there is a health centre which is mainly devoted to the welfare of pregnant women and newborn babies and infants. This is run by midwives. The hospital itself was run by a single doctor until 1979, when a second was posted. The doctors also run a small evening clinic for those who wish to consult privately.

Drugs are available from the hospital pharmacy and doctors' private clinic. However, it is possible to obtain some injectable medicines 'under the counter' from certain market traders. Drugs obtained in this way are mainly antibiotics, and in particular, penicillin.

7.18 SUMMARY

This chapter has sought to portray the variety of practitioners of medicine and to describe and analyse the prophylactic and therapeutic techniques they practise.¹ Practitioners of medicine, in general, are not differentiated from the members of the society in which they practise. They normally pursue occupations similar to those of their neighbours and kinsmen, unless their participation in the healing arts takes too much of their time. As has been indicated, medical officers and a few medical assistants are not members of the community in which they work. In this characteristic, their role is that of an outsider, along with the basīr. Medical officers, however, do not have the attachment to the community which basīrs enjoy because they do not remain for long. Every year a new individual arrives to carry out the duties of the district medical officer, thus, clearly differentiating the individual from the community. This individual then enters a small clique with other 'foreign' professionals in the area, to which few locals belong, and which cements the difference.

Apart from practitioners of medicine and a few educated Darfurians who have knowledge of the scientific view of medicine, it is likely that, from the Fūr point of view, all materia medica is regarded in a similar way - that is, by virtue of the inherent characteristics of the medicinal materials. The results of medication, it is suggested, are determined largely by analogical process in situations where the

1. Actual treatments for particular conditions will be found in Appendix 3.

scientific process is unknown. The particular characteristics of the medicinal materials undergo metamorphosis as they are prepared for ingestion or incorporation into the body as liquids, solids and vapours or applications to the surface of the body. The properties of the medicine will then, it is hoped, replace those of sickness.

In a society which has only a small literate section (in the formal sense), the 'scientific' notion of chemical and physiological pathology and medicine will necessarily require explanation and teaching in a way that is cautious, sympathetic and sensitive and does not abruptly reject the currently held beliefs. The Fūr use and appreciate modern medical drugs but there is a danger that, along with the development of modern medicine will come more drugs whose improper use will cause greater problems than they cure.

This chapter concludes Part II of the thesis, which has concentrated on sickness, its cause and conduct and the way in which medicine is practised. In Part III an account is given of social change in the field of medicine in Chapter 8 and in Chapter 9 an attempt will be made to indicate where and how social anthropological research may be of use in developing the system of health care and therapeutics in low income countries such as Sudan.